THE UNIVERSITY OF ALBERTA

A STUDY OF GROUP PLAY THERAPY APPROACHES

by

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ABSTRACT

While play therapy would appear, from a theoretical standpoint, to be a valuable medium by which to bring about change in the child's affective functioning, consistent empirical support for this stance has not yet been forthcoming. In addition, although play therapy techniques are becoming more common in the schools as preventive measures and for promoting the child's optimal adjustment, research supporting the validity of this approach is also under question. Thus the purpose of the present study was to examine the efficacy of play therapy as a treatment mode, with specific reference to its use in a preventive counselling framework.

The study focused upon the outcome components of structured, directive play therapy and an unstructured "free play" therapy approach. As the purpose of the study was to compare the efficacy of these two approaches in facilitating the affective growth of normal children, fifteen children who had not undergone, nor were, at the time of the study, experiencing emotional, learning, or behavioral problems, participated as the subjects. In addition, a preventive program is most effective when exposed to a maximum number of students. Therefore, a group setting was utilized.

The basic experimental design was that of pre- and post-testing. Standardized tests used to measure changes in self-esteem, level of anxiety, and locus of control were administered directly before and after treatment. Pre- and post-test results were then examined as to the comparative effectiveness of the two treatment approaches.

Investigation of the outcome components indicated quantitative affective changes in the unstructured play therapy group. Specific

gains included a more internal locus of control as well as a trend towards lower anxiety. Qualitative changes towards a reduction in anxiety were also noted for the structured play therapy group. Neither treatment modality was shown to effect significant changes in the children's internal or overt manifestations of self-esteem. The implications arising from these findings were discussed and suggestions were made for further research.

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CHAPTER I

INTRODUCTION

The child, through play, learns to relate to his environment and to function effectively within it (Ellis, 1973; Stinton, 1977). Play provides for the child an important medium of expression which enables him to communicate to others his thoughts and feelings. In a more universal sense, play also embraces exploration, self-testing and imitation, and assists in the preparation of children for the demands which will be placed on them in later life (Sutton-Smith, 1974). A corollary to this is that play would be a natural and valuable means by which the counsellor or teacher can reach out to, and communicate with, children and assist them in their growth. As noted by Millar (1968), play, as a therapeutic tool, is often used when working with children due to a lack of success with more traditional therapeutic modes.

Play therapy techniques were originally developed for use with 'maladjusted' children, that is, those children encountering serious social, emotional, or learning difficulties (Millar, 1968). The last 25 years, though, has seen a significant increase both in arguments for, and in the application of such techniques to 'normal' or non-disturbed children. Two theorists, in particular, who have addressed themselves to the task of broadening the scope of play therapy from the clinical setting to the school, are Clark Moustakas (1953, 1959) and George Gazda (1971, 1976). Moustakas uses a form of unstructured play therapy wherein the therapist exhibits both an acceptance of, and belief in, the child's ability to choose the direction of therapy and the play materials most conducive to his growth. Gazda's approach, on the other hand, is one of structuring or directing the play therapy

sessions along specific lines which are designated by the counsellor. Within this latter approach, the counsellor actively involves the child in such techniques as discussion groups, puppetry, and psychodrama. Although Moustakas and Gazda differ in their approaches to play therapy, both of these men are strong advocates for the use of play therapy within a preventive counselling framework, and as a means of promoting the optimal adjustment of normal children.

Moustakas believes that his unstructured play therapy approach, which he has termed 'relationship therapy', is equally applicable to both the disturbed and nondisturbed child. When speaking about the latter, Moustakas remarks:

> Play therapy is a type of preventive program of mental hygiene for normal children. They use it as a way of growing in their own self-acceptance and respect and also as a way of looking at attitudes that might not be easily explored at home or in the school (Moustakas, 1953, p.21).

A similar view as to the preventive value of play is held by Gazda. Gazda argues that as children within the age range of five to nine are play-and-action orientated, this tendency should be utilized in any type of guidance or human relations program involving children. Further, programs that are designed to enhance children's social, emotional, or vocational development, and which use play therapy techniques, will not only fit naturally into their mode of behaving but will offer an effective way of preventing maladjustment (Gazda, 1971).

Play therapy techniques can be used in an individual or group counselling setting. However, theorists such as Ginott (1961), Dinkmeyer and Muro (1971), Rose (1972), and Slavson and Schiffer (1975) to name just a few, favor working in a group setting. Dinkmeyer and Muro (1971), who take the perspective first defined by Dreikurs and

Sonstegard (1968) that man is a social, decision-making being whose actions have a social purpose, argue for a group rather than an individual setting. The group, in their opinion, offers the individual greater opportunities for discovering and experimenting with new and more satisfying ways of interacting with others. It thus allows for a greater range of experiences not present in the individual setting but which assist one in learning more effective methods of living in and dealing with a social world. In essence, a group setting has the advantage of being able to approximate the real life situation and provides a setting in which each member can test reality, and obtain feedback and support. Ideas, feelings, and concerns can be shared, thereby facilitating personal growth and improved interpersonal relations (Gazda, Duncan, and, Meadows, 1967).

There are numerous advantages and benefits for using a play therapy approach with normal children in a group counselling framework. Beginning counsellors can first master play techniques with normal children thereby giving them a solid base with which to effectively treat more severely disturbed children. As well, children experiencing serious emotional or social difficulties may be easier to identify in the play therapy setting than in the regular classroom setting. In addition, by gaining exposure to these play techniques, teachers can learn how to use play as a tool for enhancing the affective and cognitive development of their students in the regular classroom situation.

The focus of play therapy is no longer restricted to that of the purely clincial setting, with one's clientele consisting mainly of children with serious social, emotional, or learning difficulties. Play therapy is rapidly becoming incorporated in the school environ-

ment. Special emphasis has been placed by educators and therapists alike on using play therapy within a preventive group counselling framework (Nickerson, 1973; Cazda, 1976). Until recently, however, any research contesting to the effectiveness of using play therapy with normal children has been minimal, and has consisted, for the most part, of subjective reports by the counsellor or the child's teachers. Unfortunately, consensual belief does not constitute empirical validation. The result is a relative dearth of demonstrable 'content validation' with which to guide the elementary school teacher or counsellor in both the understanding and the use of play therapy techniques (Nickerson, 1973). Further research in this area may assist the teacher or counsellor with such issues as the applicability of various play therapy and play media techniques specific to the age, needs and development of the child. By focusing on the outcome components of structured and unstructured play therapy, this study proposes to determine the comparative effectiveness of these two approaches in promoting the growth of normal children within a group counselling framework.

CHAPTER II

THEORY AND RELATED RESEARCH

Theories of Play

The following theories of play, and the beliefs, convictions, and critcisms which surround them, are presented not only so as to provide a framework for this study, but also as an attempt to portray the complexity of what the concept entails and its importance in the development of the child. Play is not a wasted activity characterized by such phrases as, "He's just playing around," or "It's only make-believe," but is essential to the child's emotional, social, and cognitive growth. Play is intricately related to the child's rapidly expanding knowledge of self, the physical and social world, and the ways and means of communicating between them.

Theories of play fall into two general categories (Gilmore, 1971). Theories of play which developed prior to World War I comprise the first of these two categories. This category is commonly referred to as the 'classical' theories of play. Opposed to this first group, and containing all theories developed since 1914 to the present, is the category referred to as the 'dynamic' theories of play (for a more comprehensive overview of these theories, their assumptions, and their shortcomings, see Appendix A).

I Classical Theories

The five classical explanations of play most commonly cited in the literature are presented here. The first of these explanations argues that as a species progresses, less energy is required to maintain its self-preservation. The result is a surplus of energy which is gradually dissipated in the form of play. The opposite view is pur-

ported in another explanation, which sees play as a relaxing behavior. In this context, play effects the release of fatigue which results from undertaking those activities necessary to survival. A third explanation, which sees play as an instinctual need, able to make its presence known when none of the more powerful instincts are at work. The two remaining theories also hold the view that play is instinctual behavior, but whereas one believes play to be the instinctual practice of behavioral skills necessary for the child's survival in later life, the other theory sees play as an instinctual re-enactment of the evolution of pre-historic man to the present (In Ellis, 1973).

(a) Surplus Energy Theory

One of the first recorded attempts to explain play within a theoretical framework was initiated by Schiller in 1800, but did not receive general recognition until the publication of Spencer's writings in 1855 (Ellis, 1973). In its simplest form, Spencer's "surplus energy theory" states that because the young are freed of the task of self-preservation and survival, they are left with a surplus of energy. As Spencer believes that man is naturally an active being, this surplus creates a need for activity, which finds its expression in the aimless activity of play (Gilmore, 1971). There are numerous failings to this theory. For one, this explanation does not account for many children's ability and desire to play, even after an exhausting day, if attractive play activity is offered them (Millar, 1968). It also fails to explain the existence and prevalence of sports and dramatic play, both of which are not exclusive to children, but include adults who, in keeping with Spencer's theory, are self-preservation and survival orientated, and thus have little or no surplus energy. Nor does the theory account for the variety and diversity of ways, among adults as well as children,

that play activity can be found (Neumann, 1971).

(b) Relaxation Theory

The 'relaxation theory' put forth by Lazarus in 1883, and Patrick in 1914 explains play as a product of 'deficient' energy. In the early years of life, the child faces many more tasks which are new to him than does the adult. Fatigue arises, and play is used as a mode to dissipate the inhibitions which result from this fatigue (Jackson and Angelino, 1974). The failure of this approach is that it does not explain why children obtain pleasure from tackling difficult problems, nor does it explain why children play until they are exhausted (Neumann, 1971).

(c) Play as an Instinct

McDougall developed his explanation of play in 1923, using as his basis the early instinct theories of behavior (found in Ellis, 1973). According to these theories, instincts are pre-disposed or innate tendencies towards behaving in certain ways. Play, then is simply an instinctive need to play. Ellis (1973) notes the similarity of this position to that of the surplus energy, in describing McDougall's instinctive need, or tendency for play as, "merely surplus energy spilling over and inciting a multitude of purposeless responses, usually called forth by specific instincts" (Ellis, 1973, p.38). As well as the general criticism levelled at the instinctual theorists because of their propensity for simply devising an instinct whenever a class of behaviors needed an explanation, one of the major arguments against McDougall's theory is that it fails to explain a person's ability to learn new ways in which to play (Ellis, 1973).

(d) Pre-exercise Theory

One of the most famous theorists to view play as a form of instinctive

behavior was Karl Groos (1898, 1908), who put forward his "pre-exercise" theory of play (Jackson and Angelino, 1974). Groos believed that play is a form of practising and refining imperfect instinctive patterns of behavior for their effective use in later life. As Millar noted, "Play is the generalized impulse to practice instincts" (Millar, 1968, p.19). It is thus, a preparation for adult life, for survival in one's environment, and development of one's ability to meet the surrounding conditions.

A criticism of the 'pre-exercise' theory of play is that it implies the necessary inherent capacity to predict skills crucial to later in life (Ellis, 1973). Yet, this means having a knowledge of the future in what is a very rapidly changing world. A second argument against this theory is an adequate rationale for why adults play when they are supposedly past the stage of practising and developing their hereditary skills (Millar, 1968).

(e) Recapituation Theory

Hall's theory of play, which is best summarized in the phrase 'ontongeny recapitulates phylogeny' was elucidated in 1906 (Gilmore, 1971). Through play, the child re-enacts the evolution of his predecessors. By reliving inherited, but unnecessary and primitive skills, these instincts are gradually weakened, thus enabling the child to acquire skills needed in the future. A failure of this theory is its inability to account for play activities that reflect the time and technology of today's society (Millar, 1968). As a further example, evidence suggests that the child imitates the significant others around him rather than the behaviors of his ancestors (Gilmore, 1971).

The classical theories of play essentially concerned themselves with the antecedents of play and the inferred purposes that play serves

(Gilmore, 1971). Most of them have generally failed to rise above the status of armchair theorizing into the realm of research and, subsequently, have been discarded or have undergone modification in an attempt to bring them up to more current theoretical positions (Garvey, 1977). However, Ellis (1973), suggests that rather then discarding these theories completely, we should hold them in abeyance until they can be taken in context with the more current body of knowledge concerning play.

Two of the more recent theories of play, those proposed by Freud and Piaget, concern themselves with the specific form that play acquires, on the assumption that this is essential to specifying the causes and effects of play. As these theories are based on dynamic factors of personality and, from these personality factors, attempt to explain shifts or stages apparent in individual behavior, they have been labelled, after Piaget, the infantile dynamic theories of play.

II Infantile Dynamic Theories of Play

Both of the following explanations of play were indirect results of the more comprehensive theories on human behavior proposed by Piaget and Freud. Thus, it is suggested that both be taken in context with their respective authors' more general theoretical views. (For a more comprehensive overview of Piaget's and Freud's personality theories than is permitted by the scope of this work, see Flavell, 1963, and Hall & Lindzey, 1954, respectively).

(a) Psychoanalytic Theory of Play

Essential to the understanding of the psychoanalytic theory of play, as presented by Freud in 1908 (Gilmore, 1971), is the recognition of Freud's basic assumption that man is continually striving towards

the attainment of pleasure, and, thus, seeks to avoid conflicts which result in tension and therefore, detract from the pleasure experience. With children, conflict arises as a result of their wishes to perform activities or behaviors normally restricted to them by their environment, either because the behaviors are socially unacceptable or destructive, i.e. aggressive tendencies, or are unrealistic for their age and development, such as in wanting to be big and grownup. Through play, the child reduces the resulting psychic tensions and, in effect, gains pleasure by circumventing reality and achieving his wish fulfillments (Millar, 1968; Ellis, 1973). Another effect of play is that it enables the child to feel a sense of mastery and competence over his world. However, as noted by Gilmore (1971), this feeling of mastery "is necessarily restricted to play that serves to release a previous painful experience" (Gilmore, 1971, p.320). In this latter example, by repeating unpleasant experiences in play, the child gains understanding and, thus, power. He, thereby, obtains mastery of himself and his environment. Play, then, serves an important function in the social-emotional development of the child. In essence, by releasing tension that was caused by conflicts between his impulses (the id) and the doctrines of his society (the superego), or by incurring unpleasant experiences, the child achieves satisfaction, which is his final reward.

(b) Cognitive Theory of Play

Piaget views play as essential to the cognitive development of the child. It is a vehicle by which the child takes in, or assimilates, elements of the real world. Play becomes both a means of introducing to the child new physical and mental abilities, and an arena in which he may practice these skills, and learn, through them, to effectively

cope with his environment. As the primary importance is, then, the imparting and practice of skills, their logical pattern or the place in reality which these skills will eventually occupy is of secondary consideration. In fact, experimenting with modes of reality is a major factor in play, as the incidence of play increases proportionately with the number of different ways of thinking and acting into which reality can be distorted. Thus play is non-existant when observing the newborn baby, most evident during childhood, and eventually diminishes with the approach of adulthood when categories of reality have been set and more suitable and adaptive means of responding to the environment have been established (Gilmore, 1971).

III Current Theories of Play

The last two theories to be presented do not fall into the two previous broad classifications of play. However, they are included here as they are representative of the more recent thoughts regarding the theory of play.

(a) Learning Theory

The concept of play, according to the learning theorists, is so loose that it is almost scientifically useless (Schlosberg, 1971). Play can be explained in the same way held by the learning theorists for behavior in general, "as merely learned behavior called forth by the contingencies surrounding the player" (Ellis, 1973, p.70).

(b) Play as Playfulness

One of the most contemporary contributors to the concept of play is Sutton-Smith (found in Neumann, 1971). Sutton-Smith emphasizes the cognitive and creative functions of play. According to his theory, the child establishes through his play four 'modes of knowing': explor-

ation of one's environment, imitation of one's experiences, a testing of oneself and one's actions and, construction. He does not include these modes of knowing in his definition of play, but regards the latter simply as "playfulness". As explained by Neumann (1971), playfulness is "novelty of approach or novelty in combination of objects, experiences or ideas. 'Once the individual has made an achievement in one area by the modes of knowing, he applies it to another by playfulness" (Neumann, 1971, p.79). Therefore, playfulness permits the use of modes of knowing in a variety of ways leading to a greater adaptability to one's environment.

Summary

With the exception of the learning theorists who see play simply as behavior reinforced by positive experience, a review of various theories of play has led to the conclusion that play is not as simple a behavior as many have been led to believe. As noted by Piaget (1962), "The many theories of play expounded in the past are clear proof that the phenomena is difficult to understand...Play is not a behavior 'per se', or one particular type of activity among others" (Piaget, 1962, p.147). With all the variables within it and its numerous purported functions, play is in actuality a fairly complex phenomena. In addition, whatever theoretical stance one wishes to take, including that of the behaviorists, the common stand underlying the literature on play can be best summarized by Cass (1973): "To deny [the child] the right to play is to deny him the right to live and grow" (Cass, 1973, p.11).

Play is essential in promoting the mental, emotional, social and physical development of the child. The child uses play as a medium by which he can reach out to, and understand the world around him, and his relationship to that world. He gains knowledge of, and eventually

learns mastery over his environment. He learns body control through active, physical play. By playing with other children, whether these be imaginary playmates, or the children next door, the child acquires, and is able to practice, the rudiments of social interaction. As stated by Biber, "A child learns about the real world by playing in it" (Cited in Grey, 1974, p.47).

Paralleling the child's integration of his surrounding mileau, play is also used by the child as a means of learning about himself. The growth of the child involves a continual striving to explore, experience, and gradually develop his inner world. The act of playing enables the child to experiment with, and experience a diversity of emotions, ranging from the joy of successfully building a structure from blocks, to the portrayal of anger or pain by taking one's frustrations out on his play things. Play is related to the development of the child's self-worth. Within play, the child is afforded opportunities for successful adjustment to, and management of, himself and his environment (Caplan and Caplan, 1973). By handling play in a positive manner, the child gains confidence in himself and his ability to cope with new challenges.

In summary, play is a composite of all that childhood entails; a medium by which the child expands his knowledge of self, the physical and social world, and the ways and means he expresses and communicates to others his thoughts and feelings.

Play in Therapy

The origin of play in psychotherapy can be traced back to Freud's work with 'Little Hans' in 1909 (Millar, 1968). Freud interpreted records of the child's play according to his theory of psychoemotional development. On the basis of these interpretations, he then

offered suggestions to the child's father as to how 'Little Hans' behavior might be treated.

Melanie Klein, a follower of Freud's, started using play with children in 1919. Working on the assumption that the child is similiar in character to that of an adult, Klein saw the child's spontaneous play as analogous to the verbal free association used by Freud in his work with adults (Woltman, 1955). According to Klein, the therapist's function is in making the child aware of his pleasures, conflicts, pains and wishes, by interpreting his play to him. Her strong adherence to psychoanalysis is also evidenced in what she believes to be the aim of therapy: the nurturing and strengthening of the ego so that it can better cope with the overwhelming demands of the id and superego (Dorfman, 1951).

Freud's daughter, Anna, was the first to regard child analysis as separate and distinct from the adult variety, and modified Freud's techniques so as to make them more adaptable for use with children (Woltman, 1955). A. Freud believed that not all play is symbolic of underlying conflicts. As well, the child is viewed as incapable of developing a transference neurosis, whereby one's neurotic trends are transferred to the therapy setting. Hence, Anna cautioned against excessive use of directly interpreting the child's play back to him. Anna argued that accurate interpretive statements cannot be fully made without supporting evidence and knowledge from the child's home situation, current experiences and present wishes, fears and conflicts. For Anna, the interpretive value of play is of secondary importance. Instead, play is used by the therapist to make herself interesting, prove herself useful, and demonstrate that analysis and the analyst have practical advantages to the child. With this technique, the

therapist effects a positive emotional bond between herself and the child, thereby paving the road for actual analysis (Dorfman, 1951).

Another play therapy approach which was developed within the psychoanalytic tradition was the structured play therapy of Hambridge 1955). Basing his approach on the work done by David Levy, Hambridge argued that to make treatment more specific to the treatment task, the therapist can structure the play situation in relation to the child's current life stresses and conflicts. The function of the therapist is to judge when the use of structured play would be most beneficial to the child, using as his criteria information from the child's parents and the previous behavior exhibited by the child. The therapist is responsible for facilitating the child's play according to the problems of the child, but does not enter into the play. As stated by Hambridge, "He [the therapist] is a shifter of scenes" (Hambridge, 1955, p.608). The value of structured play therapy, as proposed by Hambridge, is in enabling the therapist to focus his attention to the specific problems of the child, to formulate and test hypotheses concerning these problems, and circumvent much of the time and energy wasted in random activities.

The approaches of Anna Freud, Melanie Klein and Gove Hambridge are all forms of analytic child therapy. A. Freud emphasizes making the child aware of material of which he was previously unconscious. According to Klein, the child's play is equivalent to the adult's free association (Millar,1968). Hambridge (1955) views his structured play approach as particularly suitable to "the release and mastery of repressed or developmentally by-passed and insufficiently lived out affect" (Hambridge, 1954, p.607). The play analysis used by each of these therapists was essentially true to the psychoanalytic tradition, with emphasis on strengthening the ego so that it might cope more effectively with the

increasing demands of the id and superego (Dorfman, 1951).

The modification and implementation of the philosophy of Otto Rank in child therapy led to significant changes and new approaches in working with children (Dorfman, 1951). Moving away from the primarily technique-orientated approach of psychoanalytic therapy, Rankian or relationship therapy believes the relationship between the therapist and child to be of utmost importance to the therapeutic process, and curative in its own right. Abandoned was the concern for the child's past and the emphasis on interpreting behavior in terms of Oedipus complex. Instead relationship play therapy places its emphasis on the immediate present. It is a dynamic interaction between the therapist and child, in the here and now, thereby creating a sense of relatedness between the two that is considered essential to the child's growth and development.

The philosophy and practice of relationship therapy were first successfully adapted to play therapy by Jessie Taft (1933) and Frederick Allan (1942). A more recent and comprehensive elaboration of the theory and process of relationship therapy, as it applies to children, has been undertaken by Clark Moustakas (1953, 1959).

The play therapy process, as approached by Moustakas, is based on the belief that "a sense of relatedness of one person to another is an essential requirement of individual growth" (Moustakas, 1959, p.2). Within play therapy the interpersonal relationship between therapist and child is viewed as "the primary facilitating factor in the child's emotional growth" (Lockwood and Harr, 1973, p.54); it is both the means and the end to therapy.

According to Moustakas (1959), two different types of relationship can occur between the therapist and child: reactive and creative. In a

reactive relationship the therapist takes on the role of a specialist. Through the processes of interpretation, questions, reflections of feeling, and emphathic listening, the therapist selects and resolves specific problems with the child. Here, the focus of therapy is not on the relationship itself, but on the child and therapist as separate individuals. In a creative relationship, which Moustakas feels is the most beneficial and conducive to the positive growth of the child, the therapist enters into the child's life as it is expressed through his play. Emphasis is placed on 'being', rather than 'doing','experiencing' rather than 'behaving' (Mooney, 1959). The focus of therapy is on what Moustakas refers to as the "present living experience" between the therapist and child, where each undergoes a continuing sense of mutuality and togetherness.

A creative relationship can be facilitated but not elicted. In order for it to occur the therapist cannot simply function as a passive mirror of the child's feelings and actions, but must become actively involved in the process of therapy. In essence, he plays with the child.

Moustakas maintains that there are three basic attitudes the therapist must possess and convey to the child in order for the relationship between therapist and child, and the consequent emotional growth of the child, to be facilitated: "faith in the child's potential for finding a healthy way, acceptance of the child's words and actions, and respect for the child's style, peculiarity, and form of expressing and being" (Moustakas, 1959, p.ix).

The attitude of faith implies the belief in the child's potential for working out his difficulties and for discovering and choosing what is best for him in his own reality. The therapist communicates to the child this belief in the latter's capacity for self-growth and self-

realization. The child, as a result, learns to believe in himself and to have faith in and take responsibility for his decisions and actions. Acceptance is a real committment on the part of the therapist, where, through his interactions with the child, he conveys an active acceptance of all of the child's perceptions, feelings, and personal meanings. This attitude is essentially the same as Roger's (1951) "unconditional acceptance".

The third attitude, that of respect, implies that the therapist believes in and communicates to the child that he is a worthwhile being as he is. The child, within this context, becomes free to express and explore his feelings and attitudes, and to discover their validity and importance relative to his own personal reality and self-fulfillment.

Non-directive play therapy, using an approach based on Carl Roger's client-centered counselling, draws a number of its working concepts from both psychoanalysis and relationship therapy. From the Freudian's, the concepts of catharsis and repression have been retained. Play, within the therapy situation is assumed to allow the child to become aware of his feelings and emotions. These emotions are released or discharged through the child's play,thereby lessening his anxiety and helping him to cope more effectively with normal social living (Millar, 1968).

The emphasis on the here and now, and on lessening the authority role of the therapist, have been adopted from relationship therapy. In non-directive play therapy, the child is allowed to choose the direction of therapy with the therapist participating at the child's discretion. The rate of therapy is dependent upon the child's psychological readiness to explore and handle the feelings and emotions under concern. In addition, emphasis is placed entirely on the present

situation of the child. As explained by Allen (1942), "Therapy is an awakening process, but if the waking up is not in the world of immediate reality, of people and events, it is not a waking up but a new medium to continue a dream existence"(Allen, 1942, p.111).

The basic assumption underlying client-centered play therapy is the belief in the child's capacity for self-determination and self-help (Dorfman, 1951). By providing the child with an atmosphere of unconditional acceptance, respect, and faith in the child and the child's potentialities, an increase in the unconditional self-regard of the child will occur (Axline, 1955). Hence, the child's belief in his own ability to cope with stressful situations is reinforced. He becomes aware of and is able to come to terms with his own real feelings, thoughts, and wishes. In short, given a conducive environment, the child has the ability to work out his difficulties, discover what is best for his personal growth, and make decisions as to how this will be effectively achieved.

As early as the third century B.C., Aristotle alluded to the viability of drama as a therapeutic technique (Roark and Stanford, 1974). However, it was not until the early 1900's, with the work of J.L. Moreno, that the full implications of action techniques, and in particular, drama therapy, became evident in psychotherapy with children.

As a teenager, Moreno gathered groups of children together for impromptu plays. Observations and study of the children in these groups initiated Moreno's eventual development of the theory and practice of a number of different and varying action modes of therapy, the most notable of these being psychodrama (Moreno, 1946).

Blatner (1973) refers to psychodrama as the enactment or re-enact-

ment of situations that involve some degree of emotional conflict for the participant at that particular point in time. In brief, the use of psychodrama is based on the assumption that conflicts are resolved through the catharsis that occurs by spontaneously playing out the conflicts with other real people who represent the people and/or objects in the conflict. Classic psychodrama focuses on pathology and usually moves towards relatively deep emotional issues.

Sociodrama is a derivative of psychodrama, but instead of working with a specific individual's problems, focus is on clarifying group themes (Corsini, 1966). More specifically, the function of sociodrama is the enactment of problems common to all members of the group, whereby each can gain insights as to more effective functioning in a particular social setting.

Drama therapy also encompasses role-playing and puppetry. Although role-playing is used extensively in psychodrama and sociodrama (Blatner, 1973), it is a valuable technique in and of itself for giving the child "a new understanding or insight into his behavior and to help him learn other, more acceptable roles for meeting social situations" (Starr, 1977, p.182). Puppetry, though not requiring the depth of physical involvement necessitated by the former modes of drama therapy, has been recognized by a variety of therapists (Woltmann, 1940; Rambert, 1949; Irwin and Shapiro, 1975) as a means of diagnosis and therapy with children. As explained by Irwin and Shapiro (1975),

> Children often experience cathartic relief as they begin to give vent to unconscious impulses through puppet or dramatic play. The main therapeutic task is working through [the child's] conflicts in a planned way to achieve insight, understanding, and change (Irwin and Shapiro,1975,p.92).

In summary, drama therapy integrates cognitive learning with the dimensions of experiential and participatory involvement. By utilizing

various action modes, the therapist assists the child in acquiring a deeper understanding of, and new insights into, his behavior, and helps him learn other, more acceptable roles for meeting social situations.

Summary

The theoretical orientations of, and techniques used in play therapy have increased dramatically in variety and number since Freud's incidental use of play in 1909. From the initial theoretical formulations concerning the value of play in psychoanalysis with children, to the present use of play in behavior therapy for modifying maladaptive behavior and teaching effective social skills (Rose, 1972), play therapy has been accepted as an effective treatment modality for working with children.

In reviewing the evolution of play as a form of therapy, two dominant themes have recently emerged in the literature: an increasing emphasis on, and attention to 1) the personal relationship between the therapist and child and its therapeutic significance; and

2) the therapist's role in play therapy in terms of how passive or active the therapist is in structuring and directing the play therapy process.

The Therapeutic Relationship

A main trend that is being found in psychotherapy today, whether it be from a psychoanalytic, client-centered, or behavioral orientation, is the emphasis on the relationship between the therapist and child as the primary factor in facilitating positive change and growth in the child (Gendlin,1966; Gazda, 1971; Lockwood and Harr, 1973). As noted by Lockwood and Harr (1973), "increasingly, the phrase 'relation-

ship therapy' [is] used to express both a specific technique and an integral part of all techniques" (Lockwood and Harr, 1973, p.54). Gazda (1971) points out that unless a strong relationship exists between the therapist and child, principles and techniques involved in play therapy have limited applicability. This is further substantiated by Truax and Carkhuff (1967) where, in a review of the literature on psychotherapy, they discovered that a necessary prerequisite for effective therapy is the development of a sound relationship involving expressions of warmth, respect and empathy.

Cutting across the variety of orientations to play therapy is a re-emphasis and focus on the living personal relationship between therapist and child in the present moment of therapy. With a movement by theorists and therapists toward real involvement and committments as persons, play therapy is changing from a professional relationship between the therapist and client to what Gendlin (1966) refers to as "a life relationship between two humans" (Gendlin, 1966, p. 202).

Therapist Intervention in Play Therapy

The acts of reaching out to and assisting the child in resolving inner conflicts and anxieties, can take many shapes and forms depending upon the orientation of the therapist, i.e., the degree to which he considers his role to be active or passive and how play is conceived to function in the treatment setting.

Some therapists, in the tradition of Gove Hambridge (1954) or Gazda (1971), stress the need for active intervention in the therapeutic process by the therapist. The therapist leads the child, structuring the direction of therapy by the introduction of specific treatment modalities. Structuring the play situation enables the therapist to focus attention, to interpret or set limits, to give approval and gain

information, or to stimulate the creative, free play of the child (Hambridge, 1955).

Underlying structured play therapy is the belief that the therapist knows what is 'best' for the child. Hypotheses are formulated according to previous and present knowledge of the child and/or general principles and concepts regarding child development. In therapy, these are tested and specific treatment techniques are applied in order to arrive at the prognosis or desired results of the therapist.

With the advent of the non-directive and relationship orientations to play therapy, came an emphasis on an unstructured approach to working with children. Direction and interpretation by the therapist is absent. The therapist's role is held by followers of non-directive therapy (Axline, 1947), to be completely passive, limited to providing a conducive atmosphere. Those in the tradition of Moustakas (1959) view the therapist's role as one of active involvement in the therapy process, similiar to a partnership with two people working together. This latter orientation, however, does not advocate the therapist leading or actively directing the process of therapy. Rather, it would be analogous to two fellow pilgrims, one of whom (the therapist) has previously travelled much of the journey into self, and so in turn helps the second pilgrim (the child) on his emotional trip by granting him the freedom to look into and become aware of his self and all the paths therein (Kopp, 1972).

In unstructured play therapy, the child is allowed almost complete freedom to choose the play activities and materials to be engaged in. This is based on the implicit assumption that the child has the capacity for self-help and will exercise this capacity given the conditions of

warmth, acceptance and understanding (Axline, 1947), and a positive growth-enhancing relationship (Moustakas, 1959). In this context, play therapy becomes 'self-therapy' with "the child as the chief agent in his own therapy" (Dorfman, 1951, p. 240).

No scientific experiment or strategem is totally free from some measure of subjective bias (Keniston, 1960). Likewise, there is no one form or procedure of therapy that is completely non-directive in the true meaning of the word. All therapy is manipulative in the sense that every therapist brings with him, into the therapeutic encounter, his personality, training, and experience. The therapist assumes a dangerously naive point of view if he perceives the response appropiate to play therapy "as that which is entirely cued by the child's behavior and occurs without prior consideration" (Lockwood and Harr, 1973, p.54). Therefore, the definition of 'unstructured play therapy', as used in this study, does not imply the absence of therapist influence on the therapy process, but instead refers to the setting up of an initial framework by the therapist, wherein the child is given the freedom to explore his thoughts, feelings, fears and wishes at his own pace. The child engages in free-choice play experiences with the therapist participating alongside or with the child. The primary role of the therapist is to utilize both his humanistic qualities and cognitive processes in order to facilitate a growth-producing relationship.

Play in Education

One implication of the intricate relationship which exists between the power of play and the child's general growth and well-being, is the recognition of the value of play within the formal educational setting of the child. There are numerous benefits and advantages to

the inclusion of play and play techniques in the child's education. Play is a valuable medium by which teachers and counsellors can reach out to and communicate with children. Various forms of play can be used to further the child's cognitive growth. The child's creativity can also be developed and enhanced through the use of play. Most importantly, play techniques may be employed not only as a preventive measure for the normal child, but also as a means of promoting optimal adjustment. It is no wonder then that the current literature on play recommends a greater implementation of classes for teachers and counsellors that pertain to play methodologies (Nickerson, 1973; Martin, 1974).

Play: A Medium for Learning

Throughout the history of early childhood education, going as far back as the Greek philosophy of Plato and Aristotle to the present day beliefs of Montessori (1964), Piaget (1962), Dewey (1966) and Sutton-Smith 1973), philosophers and educators have viewed play as the child's natural medium of learning (Neumann, 1971). Play furnishes, for the child, a method of communication which he is able to relate to and understand. Learning and the general acquisition of knowledge regarding the world one lives in are best maintained when understood and used. Whereas much of the formal verbal learning may mystify young children, as much of it outstrips their experience, conveyance of such knowledge in the form of play enables the child to grasp and use the concepts presented (Caplan and Caplan, 1974). This may be best exemplified by a study done by Amundson (1975), concerning the effectiveness of a transactional analysis program with children. Amundson discovered that teachers rated lessons requiring an active and personal involvement

by the child, as being much more effective in communicating the information of the lesson, than lessons presented in a very cognitive and rational fashion. Amundson attributes the difference in ratings to the child's greater understanding and consequent mastery of the information presented in the more experiential lessons. In essence, the child learns by doing, by becoming personally and actively involved in the learning process.

The variety and number of ways in which play can be employed as a means of communication is limited only by the imagination and ingenuity of the teacher or counsellor. Play techniques may be used to convey simple facts and figures, as noted by Moustakas' (1973) success in improvising a mathematics program. At the same time, complex patterns of behavior necessary to coping with one's social world may be effectively taught through the use of such play techniques as role-playing or sociodrama (Gazda, 1971). Regardless of the specific techniques used, play can be a valuable and important tool for the teacher or counsellor with which to acquaint the child with the nature and content of his environment.

Play as a Creative Process in Education

According to a number of studies (eg. Sutton-Smith, 1967; Dansky and Silverman, 1973; Li, 1978), there is increasing evidence pointing to a connection between play and creativity. Lieberman (1965) noted a significant relationship between playfulness and divergent thinking in kindergarten children. A study by Li (1978) found that a playful attitude is associated with an increase in novel or creative responses. Dansky and Silverman (1973) also discovered a significant relationship between play and the number of nonstandard or novel responses generated by nursery school children. The authors in the latter study pointed out

that although the children suggested a considerable number of nonstandard ways in which the treatment materials could be used, the children generally observed and stayed with the physical properties of the objects in their explanations. This finding is in agreement with both Bruner's (1976) and Koestler's (1976) views on play and the creativity process. According to these two men, all cognitive patterns and skills are governed by a fixed set of rules. Creativity occurs when a person is able to operate within the system of rules, but combines and juxtaposes them so as to arrive at an abvious but novel response. This process can be found in the works of famous musicians or artists, where images and words are never distorted, but presented in a variety of ingenious ways.

The importance of play and the creative process has, until recently, been underestimated in education. From grade one to university, the student has been pressured into a conformist's role. One must conform not only to the prescribed pattern of rules, but also to the permitted number of ways in which they might be used. It is only in the last few years that mediums which allow for the expression of the creative process, such as art and music, have gained recognition in educational theory (Grey, 1974). Yet the presence of these creative events in the play of the child, as noted by Bishop (1978), offer the child greater opportunities for learning and developing skills by which he can express and manage his feelings, thoughts and perceptions. In addition, the creative process in play enables the child to continually adjust and readjust to reality; to face reality anew.

Education is not possible without the constant interchange of thoughts, feelings and ideas. As well, one of the purported goals of education is the preparation of the person for an eventual and hopefully successful

integration into the rapidly changing world of the future. Play, as a creative process, offers both a medium of communication, and the divergent thinking necessary to successfully adapt to the constant changes in both today's and tomorrow's world.

Play as a Medium for Affective Development

A number of studies have investigated a variety of dimensions dealing with the child's affective functioning and growth (Arnold, 1960; Wight, 1971; Valett, 1974). Three of these aspects, self-esteem (Rogers and Drymond, 1954; Coopersmith, 1967), level of anxiety (Sarason, 1960; Many and Many, 1975), and locus of control (Battle and Rotter, 1963; Nowicki and Strickland, 1973) are held to have a significant effect on the overall functioning of the child.

Self-Esteem

As the child grows, he gradually gains "a sense of his presence in the world as a real, alive whole, and in a temporal sense a continous person" (Laing, 1969, p. 67). The child develops a concept of self, his own self, that is unique and distince from others. This development of the child's self-concept, which includes the "attitudes, capacities, objects and ideas which he possesses and pursues" (Coopersmith, 1967, p. 21), enables the child to form a reference point by which he can understand and become aware of his reactions to himself and the reactions of others to him.

One dimension of the self-concept that has gained particular emphasis in the literature is the construct of self-esteem (Coopersmith, 1967; Dinkmeyer, 1971; Crandall, 1973). Coopersmith (1967) refers to self-esteem as, "a personal judgement of worthiness that is expressed in the attitudes the individual holds toward himself" (Coopersmith, 1967,

p.5). A person high in self-esteem would see himself as significant, capable, and worthy. This type of individual would be creative, socially orientated, and believe himself to be able to actively influence his surroundings. Alternatively, those low on self-esteem would be best characterized as submissive, withdrawn individuals unable to realistically effect changes on their physical and social world (Coopersmith, 1967).

The results of Coopersmith's long-term study (1967) indicated that a high degree of self-esteem may be facilitated by a warm and nurturant relationship. Such a relationship not only exists in, but is the primary focus of many of the play therapy approaches today (Gendlin, 1966).

Through an "extended personal relationship such as that offered by play therapy" (Moustakas, 1955, p.83), the child is able to explore his feelings and attitudes. Negative self-evaluations are replaced by more wholesome and positive attitudes, and the child's sense of personal adequacy and worthiness is increased.

In the play therapy relationship the therapist responds in constant sensitivity to the child's feelings and conveys a consistent and sincere belief in the child and a respect for him (Moustakas, 1953). The therapist can interact with the child by using words or silence, by actively participating with the child in his play, or by passively watching, knowing that at that moment in time only his presence is necessary. In his responses to the child's play, the therapist communicates his belief in the child's potentialities for growth, respect for all of his feelings, perceptions and personal meanings, and acceptance of the child as a worthwhile being exactly as he is (Axline, 1947; Moustakas, 1955). In turn, the child's view of himself as a worthwhile person is enhanced. He comes to accept himself as he is, not

according to the conditions of worth set out by other people. The child's faith in himself and his ability to react to his social and physical world in a positive and constructive way is increased. As well, he respects his values and ways as those most suitable for him in his own reality (Dorfman, 1958).

Anxiety

Anxiety is a "conscious affective experience" (Sarason, 1960, p.31) commonly associated with feelings of fear (Moustakas, 1953), uncertainty or apprehension (Taylor, 1953), and helplessness (Horney, 1950). According to Sarason (1960), these feelings act as signals alerting the individual to possible danger to his present physical or psychological status. Once alerted the individual learns to react to such threats in varying ways and to different degrees, depending upon his personality, previous learning, and environmental conditions.

The success by which a person is able to cope with threats to his well-being, and as a consequence, reduce his level of anxiety, is dependent on a number of factors. First, when an individual's coping mechanisms are numerous and flexible, he is more likely to adapt to most situations or stimuli which might pose a threat for him. Alternatively, if his repertoire is limited and rigid, there may be situations where his reactions are inappropiate, and consequently interfere with normal adaptive functioning (Sarason, 1960).

In addition, the individual may have learned maladaptive behaviors which allow him to temporarily bypass the danger and alleviate his anxiety, but which only serve to increase his anxiety later on. According to Horney (1950), some of the causes of anxiety are a lack of respect, admiration and warmth. These attitudes result in feelings of

helplessness in the person. One method by which the individual defends against this form of anxiety is by forming "an idealized image of [his] capacities and abilities" (Coopersmith, 1967, p.33). While this initially serves to heighten his self-esteem, he is unable to realistically live up to his false hopes, and subsequently experiences failure and anxiety (Horney, 1950).

The individual's own perceptions of his self, and whether they are negative or positive, are a third factor in determining his success in defending against and coping with anxiety. A person with negative self-attitudes is marked by feelings of inadequacy and helplessness (Coopersmith, 1967). He is uncertain of how to handle threatening situations or stimuli effectively, and doubts his own ability to do so. In addition, a person with a low self-esteem experiences greater amounts of anxiety when "he expects to be or is indeed rejected or demeaned by himself or others" (Coopersmith, 1967, p.33). In basing his own conditions of worth on those set out by the significant others around him, rejections or criticisms are viewed as direct threats on his own personal worthiness.

A person who views himself in a positive and realistic manner has confidence in himself and his ability to handle anxiety-provoking situations (Coopersmith, 1967). He is better able to cope with threats in the form of actual or expected rejections by himself or others. These threats are also perceived, by the individual, as less damaging to his personal feeling of self-worth. Assured of his own success and ability to handle potential danger to his physical or mental well-being, he is able to focus his feelings of anxiety towards the source of his uneasiness, allowing for a more immediate release of the anxiety (Moustakas, 1959).

The ability of the child to cope with anxiety can be enhanced by play therapy in a number of ways. As noted by Coopersmith (1967), the value which a person places on his own success, capability, and worth, in turn, influences his subsequent success in handling a threatening situation effectively,

> Persons with positive self-attitudes apparently start from the initial position of assurance that they can deal with adversity; such attitudes may themselves be considered a form of defense or perhaps of immunity (Coopersmith, 1967, p.248).

In a play therapy relationship, the child develops positive self-attitudes leading to an increase in his self-confidence, feeling of adequacy, and belief in his own potential for self-help (Axline, 1947; Moustakas, 1953, 1959).

As cited earlier, a significant number of studies have pointed to a relationship between play and divergent thinking in children (Lieberman, 1965; Sutton-Smith, 1967; Li, 1978). Through the use of play therapy and action techniques, the child is afforded opportunities to learn and practice a variety of ways in which to effectively cope with threats to his emotional well-being. In addition, in an atmosphere of unconditional acceptance conveyed by the therapist to the child, the child is able to explore feelings of anxiety without fear of embarrassment or reprisal (Moustakas, 1953).

In summary, play therapy enhances the child's belief in his capacity to cope with anxiety-provoking situations. As well, play therapy provides the child with a repertoire of adaptive means and methods by which he can handle situations which might pose a threat to his physical or psychological well-being. Thereby, situations which can produce anxiety become less threatening.

Internal-External Locus of Control

Internal-external locus of control refers to the extent to which a person perceives reinforcement as contingent upon his own behavior and skills or as due to factors or agents independent of his own personal abilities and actions. Whereas a person with an internal locus of control would operate on the belief that he has at least some control over his destiny, a person who is externally orientated would view his acquisition of rewards as determined by luck, chance, fate, powerful others, or simply, the unpredictable (MacDonald, 1973).

Wight (1971) states that an internally directed individual is characterized "not by dependence or counterdependence, but by independence and interdependence" (Wight, 1971, p.19). In this context an 'internal' person does not fear being different, freely accepts information from others, but relies on his own good judgement and intuition when using this information, and is responsive to both his own needs and the needs of others (Wight, 1971). At the same time, externals are described by Rotter (1966) as "feeling they are controlled by powerful others, docile and suspicious" (Janzen and Boersma, 1976, p.238). Thus, externals, as opposed to internals would more likely let themselves be directed by others and would view their destiny as uncertain.

Janzen and Beeken (1973) suggest the possibility that externals may also exhibit positive characteristics,examples of these being "a more liberating attitude to interpersonal (and other) relationships" and "a greater tolerance of chaotic and unpredictable situations" (Janzen and Beeken, 1973, p.301). However, reviews of the literature (MacDonald, 1973; Nowicki, 1977) on locus of control tend towards the belief that the merits of being internal are preferable to externality

and "that it is desirable to change people, especially those who are not doing well in our society in the direction of internality" (MacDonald, 1973, p.170).

With regard to internal locus of control, some of the objectives of unstructured play therapy are to assist in the development of the child's capacity for self-determination and self-help (Dorfman, 1951; Moustakas, 1953). The child is regarded by the therapist as a person who is able to

> work out his difficulties, make decisions which contribute to personal fulfillment and...is encouraged...to come to a recognition of himself...as a participant and observer in his own growth and development (Moustakas, 1959, p.6).

In structured play therapy, such as that proposed by Gazda (1971), the therapist plays a more active role in directing the process of therapy. Specific action techniques such as role-playing, sociodrama, and puppetry are introduced by the therapist into the play therapy setting. Through the use of such techniques, the therapist leads the child towards a greater understanding of his own behavior and the roles he plays in his interactions with his environment, and how these in turn may be used in a constructive and adaptive manner to influence his social and physical surroundings.

In both structured and unstructured play therapy the child experiences a move towards an internal locus of control. He comes to expect in and rely upon his own behaviors and skills as effective in changing his external environment and in turn becomes less dependent on luck, chance or fate.

Related Research

Although play therapy appears to be accepted as a valuable tool

by which to enhance the child's social and personal adjustment (Axline, 1947; Dorfman, 1951; Moustakas, 1953, 1959; Gazda, 1971), the initial research in this area has been "meager, unsound, and frequently of a cheerful persuasive nature" (Lebo, 1953, p.177), and has consisted, for the most part, of a variety of case study protocols, 'armchair philosophy', unsupported theory, and studies complicated with faulty methodology (Ginott, 1961; McNabb, 1975). However more accurate documentation and research methods are an emerging trend in the more recent literature in the area.

Research in the area of play therapy has dealt largely with outcome measures of the pre-and post-test variety, and have been primarily concerned with changes in socialization and personal adjustment. A variety of test measures such as projective tests, sociometric measures, and standardized test instruments have been used to assess change in such areas of self-concept, level of anxiety, and interpersonal relations.

The first reported research (Fleming and Snyder, 1947) used young girls to investigate the significance of play therapy in affecting social and personal change. The test instruments used were Rogers' Personality Test, a peer rating scale, and a sociometric test of acceptance/rejection devised by Fleming. It was found that the experimental group improved more than the control group. The greatest improvement occurred in the area of personal feelings to self, while there was least improvement in social adjustment. However, this research was criticized because the experimental groups and control group were not equated for maladjustment and the treatment of the groups was not identical (Ginott, 1961).

When the nature of interpersonal relations and individual adjustment before and after therapy was investigated (Cox, 1953), a 50% improvement

in the peer ratings and adjustment scores of the experimental group was found. The subjects were matched according to responses on the Thematic Apperception Test, adjustment questionnaires and sociometric measures.

Rogers' Test of Personality Adjustment, Machover's Human Figure Drawing and Dorfman's Modified Sentence Completion Form were the measures used in a study by Dorfman (1958) designed to investigate personality outcomes of play therapy. Accompanying these tests were follow-up letters asking subjects to describe their therapy memories and current life status. The research showed improvements on the test scores but data was lacking on behavioral changes such as better interpersonal relations and more mature behavior after therapy (Ginott, 1961).

Seeman, Barry and Ellinwood (1964) conducted a study examining elementary school children's interpersonal relations following therapy. Test instruments used were Tuddenham Reputation Test and Radke-Yarrow Teacher Rating Scale. The findings suggested that the children in the experimental group were perceived by others as significantly less maladjusted after therapy.

The effect of play therapy on sociometric status and general classroom behavior was conducted by Schiffer (1966). When nine to eleven year old male clinic patients were used, it was found that although no improvement appeared in the play therapy or placebo groups, there was a deterioration in the control group. Schiffer used Peer Nomination Inventory and classroom behavior observations as test measures.

Teachers referred socially withdrawn eight and nine year old males to Clement and Milne (1967) for their study testing the effect of therapy on anxiety levels, social adjustment and academic achievement. Test instruments used were the Behavior Problem Checklist, a Q-Sort, Children's

Manifest Anxiety Scale as well as playroom observations and school grades. The boys involved in the group play therapy with tangible reinforcement improved on four of the sixteen outcome measures, whereas those in a play group without reinforcement improved on two measures, but later deteriorated on one. Both groups, including the control group, improved significantly with the Behavior Checklist and classroom observations, but not on the measure of anxiety. A later follow-up revealed the group receiving reinforcement as the most adjusted. The control group and the second therapy group showed no significant difference.

Elliot and Pumfrey (1969) found a significant difference in the adjustment scores between experimental and control groups when they tested the effect of therapy on social adjustment. The study was conducted with eight and nine year old boys of low average ability and low reading attainment. The differences the research found, however, appear to be due to outside influences such as better student-teacher relations in one of the two schools used, rather than the result of therapy. Stott Bristol Adjustment Guide (Stott, 1962) was the test measurement used.

California Test of Personality, Vineland Social Maturity Model and Haggerty-Olson-Wickman Behavior Rating Scale were the battery of tests used in a study conducted by Herd (1969). Also employed were a sociometric measure and school grades. Using children who were referred for help because of behavior problems, Herd investigated the relationship of play therapy to behavior changes in interpersonal relationships, desirable behavior patterns, more adequate use of intellectual capacities, and improved personality development. The research showed little statistical significance on the measuring data although non-statistical evidence via interviews with and letters from parents and teachers,

therapists' observations, and the children's comments appeared to suggest a treatment effect. The lack of statistical significance was thought to be due to possible insensitivity of the test instruments, the small sample size and the length of therapy.

West (1969) expressed a need for more adequate test instruments when his research showed no significant findings using Wechsler Intelligence Scale for Children, Goodenough-Harris Draw A Person Test, Self-Esteem Inventory, School Apperception Method and a sociometric measure. He was testing the effect of therapy on intelligence, self-esteem, social adjustment, and perception of school adjustment with children who had been referred due to emotional, learning or behavior problems.

Clement, Fazzone, and Goldstein (1970) researched the effect of play therapy on social adjustment and academic achievement using socially withdrawn second and third grade boys. It was found that the play therapy group receiving tangible reinforcement showed greater adjustment than a group without the reinforcement, and in turn, the latter showed significant changes over the control group. The measures used in this study were the Behavior Problem Checklist, Children's Manifest Anxiety Scale, a Q-Sort, playroom observations and school grades.

Quattlebaum (1970) used the Rorshach, Draw a Person Test and the Thematic Apperception Test in examing effect of play therapy on self-concept. The subjects of the study were maladjusted fifth grade pupils. The pre- and post-test results revealed no significant overall improvement, although the behaviors of the children did improve as a result of treatment. It was suggested that different assessment measures be investigated.

In a 1972 study, Drowne investigated the effects of verbal counselling

groups and play media groups on bringing about positive changes in self-concept. Results indicated play media techniques as the most effective approach for facilitating self-concept change in young children.

The effectiveness of play therapy on self-concept and sociometric status was investigated with second graders (House, 1971). It was found that the children in nondirective group play therapy produced significant improvement in self-concept but not in sociometric status. Scamin Self-Concept Test and a sociometric test were the testing instruments chosen.

A checklist corresponding to the characteristics of Erikson's first five stages of development (Erikson, 1950) and the Sentence Completion Test (Dorfman's modified criteria, 1955) were the test measures used in a study with underachieving children (Krivý, 1972). The relationship between adjustment and play therapy was the focus of the research. The Sentence Completion Test measured improvement in adjustment but the checklist revealed no significant changes, leading to the suggestion that the latter may not have been a valid measurement instrument.

McBrien and Nelson (1972), found no significant results when they used a sociometric test to measure sociometric status after therapy. The subjects of the study were first, second and third graders with low sociometric scores.

Pelham (1972) used kindergarten children in a study investigating the effects of play therapy in improving social maturity. The Missouri Children's Picture Series, the Children's Self Social Constructs and the Behavior Problem Checklist measured few significant differences in social maturity between the play therapy and control groups. However, teachers rated the children who received play therapy as better adjusted.

The sociometric status in school following play therapy was measured by Thombs and Muro (1973) using a sociometric scale. Grade two students with low sociometric scores were used in the study. The researchers found that the children in the play group showed a significantly greater change in social position than those in the control group, but showed no difference from the children in a verbal discussion group. As a result, the recommendation was made that group counselling, with or without the use of play media, could be used as a supplement to teacher efforts for the promotion of healthy peer acceptance.

Wall (1973) investigated the development of positive self-concept and motivation when play therapy was used. Self-Concept Motivational Inventory and Burk's Behavior Rating Scale were the test instruments used with educationally handicapped children. The assumption was made that educationally handicapped children benefit from therapeutic self-directive play following the test results showing significant positive differences in self-concept, motivation attributes and behavioral change.

Coltrane (1974) designed a sociometric instrument to use in conjunction with a behavior rating form developed by the Department of Elementary Education at the University of Mississippi and the Thomas Self-Concept Values Test for his study investigating self-image and peer status as well as the benefit of play therapy for 'emotional expansiveness'. The study was conducted on preschool and kindergarten children. Comparing the structured discussion group to the unstructured play group, Coltrane found significantly greater mean scores on the play criterion of 'emotional expansiveness', on the sociometric test and as well, significantly greater mean scores for the male subjects on one sub-section (play patterns) for the behavior rating form.

The effectiveness of play therapy for improving social adjustment

personal adjustment, self-concept, academic self-concept, behavioral maturity as rated by the teacher and inferred self-concept as rated by the parents were examined with children recommended for counselling (Barrett, 1975). The test instruments used were the California Test of Personality, the Primary Self-Concept Inventory, and the Behavioral Maturity Scale and finally, the Coopersmith Self-Esteem Inventory. Barrett discovered that children in play therapy improved significantly over the control group in social adjustment but not in personal adjustment, self-concept, or behavior as perceived by others. Following these results, it was recommended that instruments be developed or selected that were more sensitive to changes made during therapy.

Qualline (1975) assessed the effectiveness of play therapy in aiding personality adjustment, social maturity and behavior patterns for children with impaired hearing. The children ranged from four to six years of age and were described as having behavioral problems. Following an assessment with the Vineland Social Maturity Scale, The Child Behavior Rating Scale and the Behavior Problem Checklist, Qualline found the children experiencing play therapy scored significantly higher in mature behavior patterns than those in the control group. Parents and teachers of slightly over one half the children in the experimental group also saw positive behavioral change at the end of therapy.

Behavioral changes of elementary children in interpersonal relations were investigated by Sabatini (1976). The research showed that children involved in play groups were chosen by their classmates more often than those children involved in the discussion or control groups. Sabatini used a social choice inventory, a pre- and post- report of three target behaviors (i.e. socialization, creativity and maturity) by the teacher and an analysis of video-tapes of play groups. The study was criticized

for a possible contagion factor whereby the children in the play group were seen by peers to be in the more popular activity.

The most recent study reported centered upon the effectiveness of play therapy in the intellectual, social and emotional adjustment of two elementary school children (Stinton, 1977). Using a battery of tests, including the Weschler Intelligence Scale for Children-Revised (WISC-R), the Children's Apperception Test, and both the Coopersmith Self-Esteem Inventory and Behavior Rating Form, Stinton noted qualitative gains in the areas of interpersonal relations, school adjustment, self-concept, and family relations. Quantative gains were achieved on three tests having a perceptual element in common.

In reviewing these studies globally, the use of play therapy in effecting change has not been conclusively substantiated. Yet, when viewing the research relative to specific dimensions of change, one aspect of the child's functioning which is suggested by the literature to be positively altered by the use of play therapy is self-concept. However, studies in this area are minimal and fail to show a consistent tendency towards the efficiacy of play therapy as a treatment modality for children. As well, it should be noted that there is a marked absence of studies dealing with the effects of play therapy on children's locus of control and level of anxiety. Therefore the validity of using play therapy to promote the child's growth along these dimensions is still under question.

Need for Present Study

Traditionally, the school's main concerns have been with the physical and cognitive development of the child (Slavson and Schiffer, 1975). It is common practice for medical services to be part of the

school program, such as inoculating the child to prevent possible physical diseases. At the same time, the communication and learning of specific skills and knowledge has received priority in the child's education; academic learning and the competition for grades have become scholastic idols.

This almost exclusive emphasis by the schools towards the development of the child's basic academic skills, and the maintenance of his physical health, has led to the subsequent neglect of the child's emotional or affective growth. However, as noted by Wight (1971),

> To assist in balanced growth and the development of an integrated, fully functioning personality, education must concern itself with the desiring, willing, seeking,perceiving, doing, creating, evaluating, feeling aspects of behavior as well as with more common academic activities of memorizing and recalling or reproducing (Wight, 1971, p. 15).

That there is significant interaction betw the affective and cognitive components in the child's functioning has been demonstrated by Coopersmith (1959) and Brookover, Paterson and Thomas (1964).

It has only been within the last fifteen years that personal growth programs aimed at promoting the affective and social development of the child have been introduced into the schools (eg.SRA, 1964; DUSO, 1970; TAD, 1974). The common purpose behind these programs is to broaden the scope of education to where it can respond to the child as a 'whole', taking into account the child's emotional and social development in addition to the academic domain. In general, the programs are designed so as to assist in, and promote the development of coping skills by which the child can gain an awareness and understanding of his self and his ability to relate effectively to his social world. Within this context, education will no longer be restricted to schooling and instruction, but

can be equated with the promotion of growth on all levels, intellectual, emotional, and social.

The belief that play is not only conducive to, but essential for the proper affective development of the child, is mentioned repeatedly throughout the history of early childhood education. Plato, Aristotle, and Rousseau all recognized play as the child's natural medium of learning, necessary for the development of social learning and emotional expression (Neumann, 1971). A somewhat similar view is held by Slavson (1975). According to Slavson, healthy emotions can only come about when the play impulse of the child is fully satisfied.

Earlier it was mentioned that play is an effective vehicle by which to communicate concepts and ideas to children. The reverse also holds true. Schiffer (1969) points out that the child's thoughts and feelings are often too complex and difficult to be described, in their entirety, in a strictly verbal format. With a combination of words, actions, imaginative gestures and art, the child is in a much better position to work through and understand his thoughts and feelings and communicate them to others.

The child not only states who he is in his play, but also his past and his future. Using the analogy put forth by Grey (1974), play is a window, allowing information to come in from the outside world, and feelings and thoughts to be expressed from the child's inner, personal world. Slavson and Schiffer (1975) noted that those in contact with children can gain an indication as to each child's relative weaknesses by observing his play. The content of and methods by which the child plays reveal the emotional, cognitive, and physical status and development of the child (Wolfgang, 1974).

Play, within the format of affective education, would appear to be a natural and valuable means by which teachers and counsellors can reach out to, and communicate with,children and assist them in their growth. Martin (1974) argues for the use of play as an effective medium for modifying personality and behavior throughout childhood. According to Gazda (1976), play and play media techniques should be utilized in any type of guidance or human relations programs involving children. When this is accomplished, such programs would not only fit naturally into the child's mode of behaving, but would offer an effective way of preventing maladjustment. Moustakas (1953) also believes that play can be used with normal children "as a way of growing in their own self-acceptance and respect" (Moustakas, 1953, p.21). Finally, Nickerson (1973) states that play, as a treatment modality, can be used in a school setting to achieve "insight into the feelings of oneself and others, the development and change of attitudes and values, and the development of effective means to solve problems and make decisions" (Nickerson, 1973, p.364).

There are numerous advantages to using play therapy with normal children in a school setting. Play therapy can be practised in an individual or group setting. However, because children experience much of their learning through group processes (Slavson and Schiffer, 1971), group play therapy has advantages over an individual setting. For instance, it has been suggested that children are more comfortable talking about their attitudes, beliefs and feelings in groups of peers (Dinkmeyer and Muro, 1971). A group, as opposed to an individual setting, offers the child a greater opportunity to test his behavior against social reality, to obtain feedback and support from his peers and to discover that he is not alone or unique with his problems (Gazda, 1971).

In addition to these advantages, the use of group counselling in the schools would allow a greater number of children to benefit from therapy than working with individuals.

In conclusion, although play therapy would appear, from a theoretical standpoint, to be a valuable medium by which to bring about change in the child's affective functioning (Moustakas, 1953, 1959; Nickerson, 1973), consistent empirical support for this viewpoint has not yet been forthcoming. In additon, research in the area has dealt primarily with remedying already exising problems in the child's functioning. Studies attesting to the use of play therapy for enhancing the normal child's growth and development are also needed. Since normal children function most frequently in a group setting, the starting point for studies examining the efficacy of play therapy with such children should be undertaken within a group framework.

CHAPTER III

METHODOLOGY AND RESEARCH DESIGN

Selection of Subjects

The sample originally consisted of fifteen males drawn at random from a normal grade two population within a single school. A normal grade two student, as defined by this study is one who:

1. Is in a regular grade two classroom at the time the study was undertaken,
2. Is not defined as learning disabled by the teacher and/or school counsellor and has not undergone remedial education (or is presently undergoing it), and
3. Has not been recommended for and/or undergone professional counselling for serious psychological problems.

The majority of students attending this school were from families of average socio-economic status. Subjects ages ranged from seven years, one month, to nine years, two months, with a mean of seven years, nine months.

Two difficulties arose relative to the subject sample. One of the subjects in the structured experimental group had to leave the study just prior to its completion, due to his family's sudden move to another city. This reduced the overall number of subjects to fourteen. In addition, it was necessary to replace one of the subjects in the unstructured experimental group following the first session of treatment, due to his inability to fit the criteria of normality as set out by this study. Indications that the subject in question was undergoing severe emotional problems were observed by the group counsellor. Reasons pertaining to his withdrawal from the group were given to the child's

teacher and school counsellor. The counsellor received a written statement including an offer to provide individual counselling for the child at the Faculty of Education Clinical Services, University of Alberta.

Group Composition

Subjects were assigned at random to one of three groups. In one treatment group (E_1) an unstructured, free play approach was used. The second experimental group (E_2) employed a more structured approach with an emphasis on group discussion and drama techniques (Gazda, 1971). Those in the control group remained in their regular classroom setting.

The grade two students in the school under study were divided into two classrooms. The number of treatment and control group subjects obtained from each classroom is presented in Table 1.

TABLE 1

GROUP COMPOSITION AND CLASSROOM MEMBERSHIP

	Group 1 Unstructured	Group 2 Structured	Group 3 Control
Classroom 1	2	4	4
Classroom 2	3	(1)*	1
Total in each group	5	5	5

* Subject who moved away during the study

Experimental Design and Data Analysis

The basic experimental design used was that of pre- and post-testing, thereby focusing on the outcome components of the play therapy treatment procedures.

TABLE 2

EXPERIMENTAL DESIGN: SAMPLE SIZE AND DISTRIBUTION INTO GROUPS

	Group 1 Unstructured	Group 2 Structured	Group 3 Control
Pre-test	n=5	n=5	n=5
Post-test	n=5	n=5	n=5

Total N = 15

Three dimensions were selected for evaluation of change. These dimensions, and the test instruments used for their investigation, were: 1) Self-esteem, as measured by the Coopersmith Self-Esteem Inventory and the Coopersmith Behavior Rating Form, 2) Level of Anxiety, as measured by the Sarason General Anxiety Scale for Children,and, 3) Locus of Control, as measured by the Nowicki-Strickland Locus of Control Scale for Children.

Pre- and post-test mean scores were analyzed using a group within treatment design (Lundquist, 1955). The analysis took place in two parts. T-tests were used to assess the significance of mean pre- and post-scores within groups. An analysis of covarinace technique, adjusting for pre-test means between groups determined the significance of difference between the two treatment conditions and the control group.

Scheffé's multiple comparison of means technique was used to determine specific group mean differences following the analysis of covariance. Differences beyond the .05 level will be treated as significant.

Procedures

The study was conducted with the grade two students at St. Hilda's Elementary School, Edmonton, Alberta. Each of the experimental groups was scheduled to meet for ten one hour weekly sessions starting in April of the 1978 school year and ending in June, 1978. All sessions were held during school hours, Monday afternoons. However, the eighth treatment session for each group was cancelled due to the school's need for the rooms in which the sessions were held. There were no alternate facilities for the therapists' use at this time. Attempts to reschedule the sessions within the following two weeks failed due to conflicts with teachers' time requirements for the ending of the school year. Thus, treatment actually consisted of nine sessions in all.

The frameworks of G.M. Gazda's (1971, 1976) Developmental Approach to Group Counselling, and Clark Moustakas' Relationship Therapy (1953, 1955, 1959) were the specific treatment techniques for the structured and unstructured play therapy groups. For details see Appendix C.

Play Materials

While play is the child's talk, toys are his words (Ginott, 1960). The toys and materials used in each of the play groups were selected according to the criteria and recommendations set out by Lebo (1955,1958), Ginott (1961), and Cassell (1972). The unstructured play materials, that is, those items which have no preconceived impression or idea implicit in their design, consisted of paints, paper, crayons, and clay. As the treatment facilities were not equipped for sand and water

play, these materials were excluded completely. Structured items, which are clearly defined in terms of social objects and often have a specific purpose, included a Leggo set, balls, capgun, games, puppets, animal figures, bozo doll, etc.

Toys and play materials were made available to the unstructured play group throughout the treatment duration. The structured play group was exposed to these same materials for the first three sessions of treatment.

Data Collection

The Coopersmith Behavior Rating Form was completed by each subject's teacher immediately before and after treatment. The remaining instruments were administered to each child during these same times. The only exception to this occurred when the replacement of one of the subjects in the unstructured experimental group was necessitated. Results of the pre-test measures for the new subject were secured one week after those given by other subjects, but prior to his exposure to treatment conditions. The researcher and two assistants, obtained the pre- and post-test measures using the following standard instructions:

> "I would like to get to know you and here are some questions to help me do this. These are not tests; there are no right or wrong answers. I just want you to answer each question according to how you feel".

The instruments were administered verbally to each child. Testing of subjects was done in random order. Since one of the children in the structured experimental condition suddenly moved before the completion of the study, it was impossible to retest him. Therefore pre-test scores for this subject were ignored.

Therapists

Two separate counsellors, one for each experimental group, were involved in the study. Both of the counsellors had completed a graduate counselling course. As a result of their course training and practicum success in working with children under a variety of therapeutic settings, the researcher was satisfied as to their understanding and facility with the treatment techniques under study. Both counsellors were given training in the play therapy techniques and observed several sessions prior to the onset of the treatment program.

Instrumentation

Self-Esteem

One shortcoming within the literature is the lack of data on behavioral changes, such as better interpersonal relations and more mature behavior after completion of treatment (Dorfman, 1958; Ginott, 1961). Observations of a child outside of the experimental setting are needed in order to reflect actual changes in life adjustment. With this in mind, the present study employed two measures of self-esteem: the child's self-rating and a behavioral rating of the child by his teacher.

a) An assessment of the child's self-esteem, as given by the child was obtained by the use of the Coopersmith Self-Esteem Inventory (see Appendix D). Coopersmith (1967) refers to self-esteem as, "a personal judgement of worthiness that is expressed in the attitudes the individual holds towards himself" (Coopersmith, 1967, p.5). A person high on self-esteem would see himself as significant, successful, capable, and worthy. Coopersmith (1967) indicates that whereas this type of individual would be creative, socially orientated, and believe

himself to be able to actively influence his surroundings, those low on self-esteem would be best characterized as submissive, withdrawn individuals unable to realistically effect changes on their environment.

Reports on test-retest reliability vary from .88 for thiry grade five students over a five week interval (Coopersmith, 1959) to .70 for a different sample of fifty-six children over a three year interval (Coopersmith, 1967).

Employing a subject sample of one hundred and two fifth and sixth grade students, Coopersmith (1959) obtained a significant relationship between self-esteem and one's sociometric and academic status. Attempts have also been made to compare the Self-Esteem Inventory to other criteria. Studies involving cross-validation with such measures as the Weschler Intelligence Scale for Children and the Thematic Apperception Test were reported by Coopersmith in 1967. However, the results of these studies were not included.

b) Behavioral Ratings of Self-Esteem: The Coopersmith (1967) Behavior Rating Form was used to measure the child's self-esteem as inferred by the reacher (refer to Appendix E). Items in the rating scale refer to such behaviors as the child's reactions to failure, self-confidence in a new situation, sociability with peers, and the need for encouragement and reassurance. These behaviors were selected by Coopersmith (1967) on the assumption that they are indicative of the person's current appraisal of self-worthiness. This was confirmed by numerous observations of child behavior in and out of the classroom, and interviews with teachers, principals and a clinical psychologist.

In the initial use of this scale, Coopersmith (1967) obtained an interrater reliability of .73. He also discovered a general tendency

for the teachers to rate girls higher. To correct for this, separately scaled scores for the males and females in each class were established. Although this scale has, in general, had little experimental exposure to test its reliability and validity, it appears to be the best tool available to measure classroom behavior as related to the child's self-appraisal.

Level of Anxiety

The General Anxiety Scale for Children (GSAC) was used to determine each child's general level of anxiety before and after treatment (see Appendix F). Items in this scale present the child with possible anxiety provoking situations such as, "Are you sometimes frightened when looking down from a high place?", or broader questions, such as, "Do you ever worry about what other people think of you?" (Sarason, 1960).

Construct validity of this scale was based on a number of variables ranging from teachers' ratings of children's anxieties to Rorschach performance and paired associate learning (Sarason, 1960). Utilizing as his sample group 1,121 American students from grades one to six, and 788 English students from grades one to six, Sarason (1960) compared the General Anxiety Scale for Children with the Test Anxiety for Children. Median correlations between these two measures were .67 and .56 for the American boys and girls, respectively, and for the English boys .38 and the girls, .39. Within the same study, Sarason reported low negative correlations between General Anxiety Scale for Children and IQ scores and General Anxiety Scale for Children and mean achievement scores. No reliability data is given for the General Anxiety Scale for Children.

Internal-External Locus of Control

The Nowicki-Strickland (1973) Locus of Control Scale for Children

was used to measure internal-external locus of control (see Appendix G). The scale was designed to tap Rotter's (1966) construct of locus of control of reinforcement (Nowicki, 1977). As explained by Amundson (1975),

> Internality is associated with the expectancy that reinforcement is contingent upon one's own behavior, while externality is associated with the belief that reinforcement is independent of personal actions and is controlled by luck, chance, or powerful others (Amundson, 1975, p.33).

Therefore, an individual whose locus of control is inwardly orientated would perceive such occurrences as a good mark on an exam or a raise in pay as well earned, whereas an externally orientated person would likely attribute these same occurrences to lucky guesses and the boss liking him, respectively.

The Nowicki-Strickland instrument was developed in order to fill the void created by an absence of appropiate locus of control scales for children. An initial item pool of 102 items, based upon Rotter's definition of internal-external control of reinforcement dimension, was given to a group of clinical psychology staff members who were asked to answer the items in an external direction. Items for which there was not complete agreement among the judges were dropped. Item analysis was then used on the remaining items, leaving the final version of the test with 40 items.

Nowicki and Strickland (1973) recorded a split-half reliability of 0.63 for children in grades three, four, and five. In the same study, they reported test-retest reliabilities over a six week interval of .63 for third graders, .66 for the seventh graders, and .71 for the tenth graders. Correlations of the scale with the variables of sex,

social desirability and intelligence were found to be nonsignificant. The construct validity of this instrument was also investigated. In a comparison with the Bialer-Cromwell Scale (see Bialer, 1961), a correlation of .41 was found in a sample of 29 children nine through eleven years of age.

In short, the Nowicki-Strickland Locus of Control Scale for Children is currently being used in many studies (Bialer, 1961; Crandall, Kratkovsky and Crandall, 1965; Finch, Pezzuti, and Nelson, 1975). Data as to its reliability and validity are encouraging for so young a test. The Nowicki-Strickland scale is presently the best measure of locus of control, as a generalized expectancy, availabe for children (MacDonald, 1973).

Hypotheses

The group framework for research should be more applicable for generalization to the classroom setting. In consideration of the findings presented in the literature review, the following hypotheses are suggested for the present investigation:

Major Postulate

Structured and unstructured play therapy when used in a group counselling framework, will effect changes in the level of self-esteem anxiety, and internality of normal children in a school setting, as measured by differences between pre- and post- mean scores on the Coopersmith Self-Esteem Inventory, Behavior Rating Form, Sarason's General Anxiety Scale, and the Nowicki-Strickland Locus of Control Scale for Children.

Specific Hypotheses

The following hypotheses, in null form ($Ho: \mu_1 = \mu_2 = \mu_3$) will be

used in the present study.

Ho_1: There will be no significant differences in adjusted mean post-test scores of self-esteem, as measured by the Self-Esteem Inventory, between groups after participation in the treatment program.

Ho_2: There will be no significant differences in mean scores of self-esteem on the Self-Esteem Inventory within groups on the pre- and post-test measures.

Ho_3: There will be no significant differences in adjusted mean post-test scores of self-esteem as measured by the Behavior Rating Form, between groups after participation in the treatment program.

Ho_4: There will be no significant differences in mean scores of self-esteem on the Behavior Rating Form within groups on the pre- and post-test measures.

Ho_5: There will be no significant differences in adjusted mean post-test scores of anxiety, as measured by the General Anxiety Scale, between groups after participation in the treatment program.

Ho_6: There will be no significant differences in mean scores of anxiety on the General Anxiety Scale within groups on the pre- and post-test measures.

Ho_7: There will be no significant differences in adjusted mean post-test scores of externality as measured by the Nowicki-Strickland Locus of Control Scale, between groups after participation in the treatment program.

Ho_8: There will be no significant differences in mean scores of externality on the Nowicki-Strickland Locus of Control Scale within groups on the pre- and post-test measures.

CHAPTER IV

RESULTS

Introduction

As stated in Chapter III, a total of 14 grade two students participated in the study. The study was held in the same school in which the students attended in order to be able to generalize treatment effects to a school setting.

The major postulate of this study is that structured and unstructured play therapy, when used in a group counselling framework, will effect changes in the affective functioning of normal children in a school setting.

Findings of the Study

Tests to differentiate between the experimental and control groups' pre-test means were performed on the mean scores of the Self-Esteem Inventory, Behavior Rating Form, Anxiety Scale, and Locus of Control Scale. A summary of these results, as presented in Appendix H, Table 11, indicated that the pre-test means across groups on the Anxiety scale were significantly different ($F = 25.12$, $p < .001$). Differences between the pre-test means across groups also approached significance with the Self-Esteem Inventory ($F = 4.47$, $p < .06$) and the Behavior Rating Scale ($F = 4.62$, $p < .06$). Thus, an analysis of covariance employing adjusted means was used to control for unequal variances between experimental and control pre-test means across the four dimensions. The pre- and post-test and adjusted means for each of the four dimensions under investigation are presented in Appendix H, Tables 12 through 15.

Hypothesis I

Hypothesis I stated that "there will be no significant differences

in adjusted mean post-test scores of self-esteem, as measured by the Self-Esteem Inventory, between groups after participation in the treatment program". As can be seen from Table 3, the difference between the adjusted post-test means of the experimental and control groups on the Self-Esteem Inventory was not significant ($F = 0.17$, $p > .05$). Hypothesis I was supported.

Hypothesis II

Hypothesis II predicted that "there will be no significant differences in mean scores of self-esteem on the Self-Esteem Inventroy within groups on the pre- and post-test measures". A summary of the results is presented in Table 4. No significant differences were found between the pre- and post-test means of the experimental and control groups on the Self-Esteem Inventory. Therefore, Hypothesis II was supported. ($t = .79$, $p > .05$)

Hypothesis III

Hypothesis III predicted that "there will be no significant differences in adjusted mean post-test scores of self-esteem, as measured by the Behavior Rating Form, between groups after participation in the treatment program". As noted in Table 5, no significant changes in self-esteem scores, as measured by the Behavior Rating Form, were noted across groups ($F = 0.10$, $p > .05$). Hypothesis III was supported.

Hypothesis IV

Hypothesis IV stated that "there will be no significant differences in mean scores of self-esteem on the Behavior Rating Form within groups on the pre- and post-test measures". As indicated by Table 6, the differences in means scores on the Behavior Rating Form within experimental and control subjects on pre- and post-test measures were not significant ($t = 1.87$, $p > .05$). Hypothesis IV was supported.

TABLE 3

Analysis of Covariance of Self-Esteem Scores
on post-test Employing Adjusted Means

Source	df	M.S.	Adjusted F	Probability Level
Effects	2	23.17	0.17	0.84
Error	10	131.29		

TABLE 4

T-Test of Self-Esteem Scores
on Pre- and Post-test Group Means

Source	Pre-test Means	Post-test Means	t
Treatment 1	80.80	82.40	0.41
Treatment 2	70.50	72.50	0.70
Control	66.40	70.80	0.79 *

* $p > .05$

TABLE 5

Analysis of Covariance of Behavioral Scores on Post-test Employing Adjusted Means

Source	df	M.S.	Adjusted F	Probability Level
Effects	2	3.54	0.10	0.89
Error	10	33.04		

TABLE 6

T-Test of Behavioral Scores on Pre- and Post-test Group Means

Source	Pre-test Means	Post-test Means	t
Treatment 1	46.40	43.40	1.87 *
Treatment 2	47.25	47.25	0.30
Control	47.20	46.20	0.44

* $p > .05$

Hypothesis V

Hypothesis V stated that "there will be no significant difference in adjusted mean post-test scores of anxiety, as measured by the General Anxiety Scale, between groups after participation in the treatment program". Table 7 revealed no significant differences in adjusted post-test scores of anxiety between the treatment and control groups ($F = 0.56$, $p > .05$). Therefore, Hypothesis V was supported.

Hypothesis VI

Hypothesis VI predicted that "there will be no significant differences in mean scores of anxiety on the General Anxiety Scale within groups on the pre- and post-test measures". A summary of the results obtained in testing this hypothesis is found in Table 8. Inspection of Table 8 found a significant difference between the pre- and post-test scores on the Anxiety Scale in Treatment 1 ($t = 3.07$, $p < .05$). Although significant differences were not found between pre- and post-test scores for Treatment 2 (Structured play group), ($t = 0.54$, $p > .05$), or for the Control group ($t = 0.17$, $p > .05$), the children in Treatment I (Unstructured play group) evidenced a significantly lower level of anxiety subsequent to participating in the treatment program.

Hypothesis VII

Hypothesis VII predicts that "there will be no significant differences in adjusted mean scores of externality, as measured by the Nowicki-Strickland Locus of Control Scale, between groups after particiaption in the treatment program". As can be seen from Table 9, the difference between the adjusted post-test means of the treatment and control groups on the Locus of Control Sclae was significant ($F = 5.64$, $p < .05$). Hypothesis VII was rejected.

TABLE 7

Analysis of Covariance of Anxiety Scores on Post-test Employing Adjusted Means

Source	df	M.S.	Adjusted F	Probability Level
Effects	2	16.68	0.56	0.58
Error	10	29.32		

TABLE 8 **

T-Test of Anxiety Scores on Pre- and Post-test Scores Within Groups

Source	Pre-test Means	Post-test Means	t
Treatment 1	27.40	31.80	3.07 *
Treatment 2	21.75	26.50	0.54
Control	20.00	19.40	0.17

* $p < .05$, ** Scores inversely related to level of anxiety.

TABLE 9

Analysis of Covariance of Locus of Control Scores on Post-test Employing Adjusted Means

Source	df	M.S.	Adjusted F	Probability Level
Effects	2	16.81	5.64	0.02
Error	10	2.97		

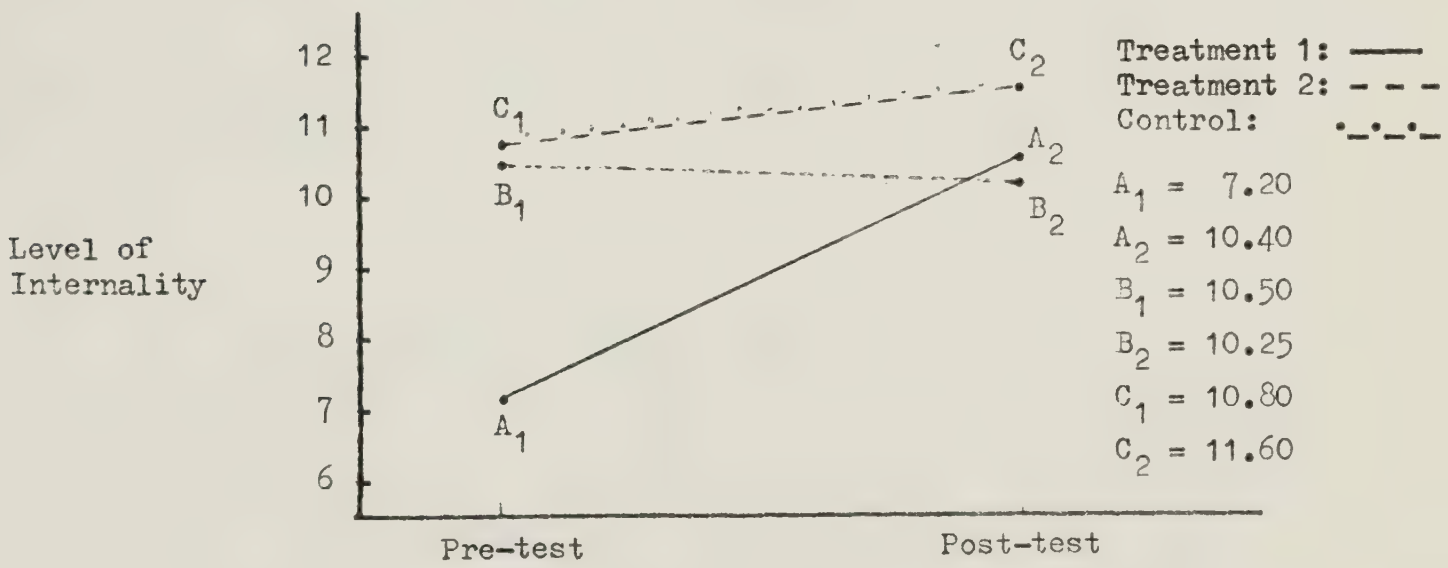

FIGURE 1
Interaction Between Broups and Time on the Dimension of Internality

In order to demonstrate the specific group mean differences, the groups by time effect on the dimension of externality is presented in Figure 1, followed by the results of the Scheffe multiple comparison of means technique.

In Figure 1, '$A_1 - A_2$' appears to have a steeper rate of incline than '$C_1 - C_2$', whereas in '$B_1 - B_2$' a slight decline in scores is observed. A comparison of mean differences across the three groups indicated that Treatment 1 (Unstructured play therapy) was significantly more effective in bringing about change to a more internal locus of control than Treatment 2 (Structured play therapy) (T2 - T1, $F = 4.01$, $p < .05$), or the control group (C - T1, $F = 4.19$, $p < .05$).

Hypothesis VIII

Hypothesis VIII states that "there will be no significant differences in mean scores of externality on the Nowicki-Strickland Locus of Control Scale within groups on the pre- and post-test measures". A summary of the results obtained after testing this hypothesis are presented in Table 10.

TABLE 10

T-Test of Locus of Control Scores on Pre- and Post-test Scores Within Groups

Source	Pre-test Means	Post-test Means	t
Treatment 1	7.20	10.40	5.48 *
Treatment 2	10.50	10.25	0.14
Control	10.80	11.60	0.54

* $p < .005$

As noted in Table 10, Hypothesis VIII was rejected. The pre- and post-mean scores were significantly different in Treatment 1 as assessed by the Locus of Control scale ($t = 3.07$, $p < .005$). Those children experiencing unstructured play therapy moved significantly in the direction of a more internal locus of control. Similiar changes were not obtained when comparing pre- and post-test mean scores for Treatment 2 (Structured play therapy) ($t = 0.54$, $p > .05$).

Summary

This study investigated the efficacy of structured and unstructured play therapy when applied in a group counselling framework. It was expected that these two approaches would positively alter the normal child's affective growth and development. Specific dimensions of change under investigation included both internal and behavioral manifestations of self-esteem, as well as self-report measures of anxiety and locus of control.

Both internal and behavioral manifestations of self-esteem remained relatively stable within and between groups. That is, there were no differences between experimental and control subjects on pre- and post-test measures. T-tests comparing pre- and post-mean scores on the General Anxiety Scale found a significant gain for the unstructured play therapy group. However, these results were not supported by an analysis of covariance. Thus, although children in the unstructured group evidence a lowering of anxiety, this difference was not large enough to argue that this particular treatment modality was significantly more effective in reducing anxiety than the structured play therapy or control group. The children in the unstructured play group did show a significant change towards a more internal locus of control. This was confirmed by analysis of covariance, T-tests, and the Scheffe multiple comparison

of means. (See Appendix H, Table 16).

In summary, the outcome components indicated quantitative affective changes in normal children. These changes appear to be a result of participating in unstructured play therapy within a group counselling framework. Specific changes included a more internal locus of control as well as a trend towards lower anxiety. Similiar changes were not found in the structured play therapy group nor in the control group. In addition, neither treatment modality was shown to effect significant changes in the children's internal or overt manifestations of self-esteem.

CHAPTER V

SUMMARY, DISCUSSION AND IMPLICATIONS

Summary

Play is used by the child to assist in the exploration and understanding of his surroundings, his inner personal world, and the relationship that exists between them. Recognizing the intricate and important role of play in the development of the child, play has been accepted as both a means and a medium for treating children with emotional or behavioral problems.

The use of play and play media techniques, as a form of therapy, has gradually expanded from a purely clinical setting to its present use in the schools. However the focus of treatment has traditionally remained one of remediation, due in part to the original clinical orientation, and in part, to restraints in time and resources, thus limiting treatment to those most in need of help.

Within the last fifteen years a gradual shift in educational priorities has taken place. The role of the schools is no longer restricted to facilitating the child's physical and cognitive development. Instead, there is an active movement in the schools to include the child's emotional or affective growth as part of the educational process. Paralleling this movement is an increase both in arguments for, and in the application of play therapy techniques to 'normal' or non-disturbed children, both for preventive purposes and for the enhancement of the child's optimal growth and development.

Play therapy, in the schools, can be practised in a group setting. Children naturally experience much of their learning in a social context. In addition, a group framework would afford the counsellor or

teacher maximum exposure to the maximum number of students, thereby alleviating time and resource constraints.

From a theoretical standpoint, play therapy would appear to be a valuable medium by which to bring about changes in the child's affective functioning. However, empirical support for this viewpoint is as yet inconclusive. As well, research in the area has dealt primarily with remedying already existing problems in the child's functioning. There is a definite lack of studies attesting to the use of play therapy for enhancing the normal child's affective growth and development.

The purpose of this study was to investigate the efficacy of structured and unstructured play therapy, when applied in a group counselling framework, on the affective functioning of normal children in a school setting. The frameworks of G.M. Gazda's (1971, 1976) Developmental Approach to Group Counselling, and Clark Moustakas' Relationship Therapy (1953, 1955, 1959), were the specific treatment techniques for the structured and unstructured play therapy groups. The specific dimensions of change under investigation included both internal and external perceptions of self-esteem, as well as self-report measures of anxiety and locus of control.

An analysis of covariance with adjusted post-test means was utilized to measure changes between the experimental and control groups. T-tests were also employed to assess differences between pre- and post-test mean scores within each of the three groups.

Analysis of covariance on the results of the Self-Esteem Inventory failed to indicate significant differences between the experimental and control groups. In addition, internal and external ratings of self-esteem did not change significantly within each of the three groups, as measured by differences between pre- and post-test mean results.

T-tests comparing pre- and post mean results on the General Anxiety Scale indicated that the unstructured play therapy group's scores changed significantly ($p<.05$) whereas the scores for the structured play therapy and control groups did not. However, an analysis of covariance with adjusted post-test means indicated that the unstructured experimental group's scores did not change significantly more than the scores for the structured experimental or control group.

Analysis of covariance of Locus of Control results indicated significant differences between experimental and control groups on the adjusted post-test means ($p< .05$). T-tests and the Scheffé multiple comparison of means were employed to assess specific differences across and within groups. Results favored the unstructured play therapy group, where a significant change towards a more internal locus of control was noted ($p<.005$).

Discussion of the Results

One possible explanation as to the lack of change in internal or overt manifestations of self-esteem as measured by the Self-Esteem Inventory and Behavior Rating Form, may be related to treatment duration and degree to which self-concept is amenable to change. Bem (1972), Super (1963) and Shavelson et. al (1976) suggest that the "structure of self-concept [of which self-esteem is the evaluative component] may be hierarchical on a dimension of generality" (Shavelson et.al, 1976, p.412). At the apex of this hierarchy is general self-concept which comprises the individual's total view of himself. The general self-concept may be divided into the academic and non-academic self-concept. Whereas academic self-concept may be broken into subject matter areas, divisions of non-academic self-concept may include such

divisions as peers, significant others, and one's physical well-being. Taking this one step further each of these dimensions would be made up of,and determined by,situation-specific behaviors, which form the base of the hierarchy.

According to this framework, general self-concept is stable and resistant to change. This would appear to be in agreement with studies by Roth (1959), Coopersmith (1967),Ludwig & Maehr (1967), and Purkey (1970). However, the further down the hierarchy, the less stable becomes the self-concept and the more it becomes dependent upon situation-specific behaviors.

Shavelson et. al.(1976) suggest that in order to change an individual's general self-concept, he would have to experience many situation-specific changes contrary to his general concept of self. For example, a child may feel that he does not have any friends, that he is unliked and unlikeable by those around him. He meets a boy at school who gives him a piece of candy. This specific instance may not be enough to make the child feel that he is now a likeable person. However, if he continues to meet other children who continue to offer him treats, praise his successes, and console him when he loses, then his concept of himself will gradually change from unliked and unlikeable to that of feeling that he is worthy as a friend. Reversing the hierarchy, as these specific changes in self-concept occur, they in turn influence perceptions of self across situations, thereby determining the person's overall or total concept of self.

By definition, Coopersmith's Self-Esteem Inventory focuses upon,

> the relatively enduring estimate of self-esteem rather than upon more specific and transitory changes in evaluation (Coopersmith, 1967, p.5).

Although the Self-Esteem Inventory does measure the child's subjective evaluations about himself as related to his home, school, and peers, the items are generally not situation-specific. On the same note, whereas teacher's perceptions of the child's self-esteem tend to be activity and performance based, items on the Behavior Rating Form appear to be related more to an academic self-esteem rather than specific situations within the classroom. Thus, situation-specific changes in self-esteem for the children in the structured and unstructured play therapy groups may have occurred as a result of treatment, but may not have been indicated by the Self-Esteem Inventory or the Behavior Rating Form due to possible insensitivity of the instruments. Alternatively, length of treatment may not have been of sufficient length to bring about the number of situation-specific changes needed to effect change in the more general dimensions of self-esteem as assessed by the two instruments. The short treatment period and possible insensitivity of the self-esteem measures would also explain the results of studies by West (1969), and Stinton (1977), where significant quantitative changes in self-esteem, as measured by the Self-Esteem Inventory and Behavior Rating Form, were not indicated.

Whereas children in the unstructured play therapy group evidenced a significant change towards a more internal locus of control, similiar changes were not found for the structured play therapy or control groups. Differences between the two experimental groups, as measured by the Locus of Control Scale, may be explained in terms of the different treatment approaches utilized by the two play therapy groups.

Unstructured play therapy, as employed in this study, followed the framework of Clark Moustakas' Relationship Therapy (1953, 1955, 1959). The therapist, within this context, sets up an initial framework for

therapy, wherein the child is given the freedom to explore his feelings, thoughts, fears and wishes at his own pace. In addition, the child is given almost complete freedom to choose the direction of therapy. Underlying this approach is not only a belief by the therapist in the child's potential for working out his difficulties and for discovering and choosing what is best for him in his own reality, but an active conveyance of this belief by the therapist to the child.

In the structured play therapy group, wherein G.M. Gazda's Developmental Approach to Group Counselling (1971,1976) was employed, the therapist played an active role in directing the process of therapy. Specific action techniques such as role-playing, puppetry and sociodrama were introduced into the play therapy setting by the therapist. It was postulated that through the use of these techniques the therapist would lead the child to a greater understanding and awareness of his current behavior and its impact on his environment. In addition, such techniques would be utilized to teach the child new ways and means by which he may influence his social and physical surroundings in a constructive and adaptive manner.

Internal locus of control, as defined earlier in this study, refers to an individual's belief that his destiny is to at least some extent, under his control; that reinforcement received from the environment is contingent upon his own behavior and skills. Conversely, an externally orientated person would perceive the acquisition of rewards or punishment as dependent upon such factors as luck, chance or powerful others.

In the unstructured play therapy group the children were given the responsibility for the direction of therapy, the rate at which it was to proceed, and any consequences which resulted from their decisions. Thus it would appear that these children not only learned that their

behavior could have an effect on their immediately surrounding environment, but in addition, were able to experience and direct the consequences of their actions. Although the children in the structured play therapy group may have learned that reinforcement was, to some extent, contingent upon their behaviors, the direction and rate of therapy was, to a major extent, beyond their control. In essence, the acquisition of rewards in the immediate context of therapy was dependent upon the actions and directions of a powerful other, the therapist.

The structured and unstructured play therapy groups, when compared to the control group, did not show a significant decrease in anxiety as assessed by the General Anxiety Scale. However, a comparison of pre- and post-test anxiety scores for the unstructured play therapy group indicated that significant changes within this group had occurred over treatment. At the same time, these changes may not have been great enough so as to show a difference when compared to the control group but, nevertheless, do show a movement towards a reduction in anxiety. Therefore, a longer treatment period may have been required for differences to become evident.

When examining the results which occurred within the structured and unstructured play therapy groups, only the latter showed significance when comparing pre- and post-test means. However, when referring to the mean pre- and post-test anxiety scores for the experimental and control groups as listed in Table 8, it can be seen that the difference between the pre- and post-test mean scores for the structured play therapy groups was greater than that found for the unstructured play group. A probable explanation as to why the difference between pre- and post-test means was treated as significant for the unstructured play group

but not for the structured group, could be attributed to differences in the relative sample sizes of the two groups. Initially each treatment group was composed of five students. However this number was subsequently reduced to four for the structured play group due to a loss of one of its members during the treatment period. As noted in Ferguson (1976), when working with sample sizes similiar to those employed in this study, the smaller the sample size, the less chance that a significant change in scores would be indicated by the use of parametric statistics, such as that of a T-test. Thus, the discrepency between the two treatments in terms of results indicated as significant would probably be due to the effect of the relative sample sizes on the analysis of the results rather than specific differences in anxiety scores between experimental groups.

Results as Related to Previous Research

Evidence pertaining to the use of play therapy as a means for bringing about change in the child's social, emotional, or cognitive functioning has gradually shifted from subjective evaluation to empirical validation and documentation. Although studies on play therapy are still minimal in number, and generally are inconclusive, an area of the child's functioning which does appear to be affected by play therapy is the child's self-concept (Quattlebaum, 1970; House, 1971; Wall, 1973; Coltrane, 1974).

Support for using play therapy to effect positive change in children's self-concepts was not forthcoming in this study. Differences in outcome between this and self-concept studies cited previously may be due to a number of factors. However, in reviewing the empirical research to date, studies utilizing the self-concept measures employed by this study also failed to obtain significant quantitative results

(West, 1969; Stinton, 1977). As noted earlier, the Self-Esteem Inventory and Behavior Rating Form are general measures of self-esteem. Although situation-specific changes in self-esteem may have occurred in this and the previous two studies the test instruments may not have been sensitive to their occurence.

Anecdotal evidence in the form of the participating therapists' perceptions and verbalizations of changes in the childrens' self-concepts, in addition to comments made by some of the children involved, indicate that qualitative changes may have taken place. Similiar qualitiative differences were also observed by Stinton (1977). A recommendation for more stringent assessment measures, as found in the only other study (Barrett, 1975) where a failure to achieve significant results was noted, may be applicable to this study.

A belief held by many therapists, such as Horney (1950), Hambridge (1955), Moustakas (1955, 1959), and Irwin and Shapiro (1975), is that anxiety decreases as therapy progresses. However, attempts to empirically validate this belief are noticeably lacking in the literature on child psychotherapy, particularly in the area of play therapy. The only reported research directly assessing the effects of play therapy on anxiety (Clement and Milne, 1967) failed to find significant differences in change between the treatment and control groups. Similiar results were found for this study.

In their 1967 study, Clement and Milne postulated that their failure to achieve statistically significant differences in anxiety after treatment may have been due, at least in part, to the relatively short treatment duration. As noted in the present study, within treatment group differences were observed in the direction of decreased anxiety, but were not great enough to indicate a significant reduction in anxiety

when compared to the control group. In essence, the approaches to play therapy used in the present study, and in the study by Clement and Milne (1967), do not appear to effect significant quantitative changes in childrens' level of anxiety over a short period of time. Although the data suggests that significant changes in anxiety may occur given a longer period of treatment, further research is needed before this can be conclusively substantiated.

At present, there are no reported studies dealing with the effects of play therapy on locus of control. Therefore, the results of this study cannot be discussed relative to previous studies with play therapy in this area.

Critical Evaluation and Implications for Further Research

Until recently, much of the work performed by counsellors in the schools has dealt with the remediation of children's exisiting behavioral, emotional, or cognitive problems (Sallade, 1972; Martin, 1973; Nickerson, 1973). Paralleling this was an almost exclusive focus on the cognitive and physical education of the child to the apparent neglect of the child's affective development. Gradually a shift in scholastic objectives has evolved towards including the affective education of the child. Accompanying this transition has been the introduction of human development programs, such as SRA (1964), DUSO (1976), and TAD (1974).

Given the importance of play in the emotional and behavioral development of the child, play therapy would appear to be a valuable tool in enhancing the normal child's affective growth in the schools. Evidence as to the specific ways in which play therapy can enhance and facilitate the normal child's affective development is presently limited. This

study's results confirm Coltrane's (1974), and Sabatini's (1976) findings that positive changes occur in the child's social or emotional functioning, when exposed to the play therapy process. In addition, the present study offers possible approaches to utilizing play for the enhancement of the child's affective growth, with specific reference to the development of a more internal locus of control.

In further reviewing the study, certain limitations became apparent. A longer period of treatment and the use of larger samples may have resulted in a more noticeable change in test scores. In addition, unequal means between the experimental and control groups were noted on the various pre-test measures. This made the comparison of experimental and control groups more difficult when analysing treatment effect. Observational and anecdotal information suggests that situation-specific changes occurred in some of the children's self-esteem. Perhaps a more stringent and specific assessment device for measuring changes in self-esteem may have been used.

Four potential areas of related research are;

1. Due to the small sample sizes used in the present study, large differences in test scores are needed before they can be portrayed by traditional statistical analyses. In addition, results obtained when using a small sample size are more susceptible to attrition than if a large sample is employed. However, play therapy decreases in effectiveness when the play group size increases to more than five to six children and only one counsellor is involved. An alternative for further research would be to use two or more equal groups for each treatment approach and for the control sample.

2. The sample employed in this study consisted of grade two boys.

Studies utilizing all girls, or a combination of boys and girls for their subject samples would assist to determine if similiar results occur.

3. In this study, two treatment groups and a control group were used. The inclusion of a placebo group would allow for a more accurate determination of the results of therapy itself. The placebo group could take the form of a "free play" group,with or without a counsellor present. The experimental and control groups could also be matched on such variables as intelligence, sociometric status, and results from pre-test scores, and would thus allow for more generalizable conclusions.

4. The present study was conducted for only nine weeks with a session once a week. As the use of play therapy in a preventive counselling framework is still relatively new, it would be valuable to investigate changes in the self-concept, anxiety, and locus of control of normal children over a longer period of time and with different play therapy approaches. An elaboration of this would be additional studies on process components of play therapy as related to these dimensions of change. Through this type of research, particular strengths of play therapy when employed with normal children might be identified.

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APPENDIX A

THEORIES OF PLAY

REPRODUCED FROM: ELLIS, M. J. WHY PEOPLE PLAY
PRENTICE HALL, 1973
pp. 46-47, 78-79, 111.

Table 3.1

Classical Theories of Play

NAME	PLAY IS CAUSED:	THIS EXPLANATION ASSUMES THAT:	IT CAN BE CRITICIZED BECAUSE:
1a. Surplus Energy: I	by the existence of energy surplus to the needs of survival	1. energy is produced at a constant rate 2. if stored, storage is limited 3. excess must be expended 4. its expenditure is made on overt behavior which is by definition play	1. children play when fatigued or to the point of fatigue, so a surplus is not necessary for play 2. the process of evolution should have tailored the energy available to the energy required
1b. Surplus Energy: II	by increased tendency to respond after a period of response deprivation	1. all response systems of the body have a tendency to respond 2. the response threshold is lowered by a period of disuse 3. after periods of disuse, eventually all available responses should reach a low enough threshold to be discharged either by some stimulus events or spontaneously.	1. some responses available to the persons are never used
2. Instinct	by the inheritance of unlearned capacities to emit playful acts	1. the determinants of our behavior are inherited in the same way that we inherit the genetic code which determines our structure 2. some of those determinants cause play	1. It ignored the obvious capacity of the person to learn new responses that we classify as play 2. the facile naming of an instinct for each class of observed behavior is to do no more than to say, "Because there is play, there must be a cause which we will call an Instinct."

3. Preparation	by the efforts of the player to prepare for later life	1. play is emitted only by persons preparing for new ways of responding 2. the player is instinctively prepared for responses that will be critical later 3. the instincts governing this are inherited imperfectly and youth is the period during which these imperfectly inherited mechanisms are perfected	1. play occurs most frequently in animals that live in rapidly changing circumstances 2. it requires that the player inherit the capacity to predict which responses will be critical later. This requires the inheritance of information about the future 3. people do not stop playing as adults, when presumably they are acceptably prepared
4. Recapitulation	by the player recapitulating the history of the development of the species during its development	1. the critical behaviors occurring during the evolution of man are encoded for inheritance 2. a person emits some approximation to all these behaviors during his development 3. since these behaviors are currently irrelevant they are play 4. the stages in our evolution will be followed in the individual's development	1. there is no linear progression in our play development that seems to mirror the development of a species. At one point, late boyhood and adolescence, there may be similarity between sports and games and the components of hunting, chasing, fighting, etc., but before and after there seems little relation 2. it does not explain play activities dependent on our advanced technology
5. Relaxation	by the need for an individual to emit responses other than those used in work to allow recuperation	1. players work 2. play involves the emission of responses different from those of work 3. the emission of different responses eliminates the noxious byproducts of work	1. it does not explain the use in play of activities also used in work 2. it does not explain the play of children—unless they are clearly working some part of their day

Table 4.1

Recent Theories of Play

NAME	PLAY IS CAUSED:	THIS EXPLANATION ASSUMES THAT:	IT CAN BE CRITICIZED BECAUSE:
6. Generalization	by the players using in their play experiences that have been rewarding at work	1. there are at least two separable categories of behavior 2. the players transfer to play or leisure, behaviors that are rewarded in another setting 3. to be useful we understand what rewards individuals at work	1. it seems to exclude play of preschool children 2. it assumes that at least some aspects of work are rewarding
7. Compensation	by players using their play to satisfy psychic needs not satisfied in or generated by the working behaviors	1. there are at least two separable categories of behavior 2. the player avoids in play or leisure behaviors that are unsatisfying in the work setting experiences that meet his psychic needs 3. to be useful we understand the mismatch of needs and satisfactions in the work setting (or vice versa)	1. it seems to exclude play of preschool children 2. it assumes that work is damaging or does not satisfy some needs
8. Catharsis	in part by the need to express disorganizing emotions in a harmless way by transferring them to socially sanctioned activity. This concept has been limited almost entirely to questions of aggression, and will be so here	1. frustration of an intention engenders hostility towards the frustrator 2. this frustration or hostility can be redirected to another activity 3. this hostility must be expressed to reduce psychic and physiological stress	1. it is a partial explanation for only the compensatory behavior engendered by hostility 2. the data show conclusively that sanctioning aggression increases it 3. the planning of activities to provide outlets for aggression constitutes its sanctioning

9a. Psychoanalytic: I	in part by the players repeating in a playful form strongly unpleasant experiences, thereby reducing their seriousness and allowing their assimilation	1. stimulating unpleasant experiences in another setting reduces the unpleasantness of their residual effects	
9b. Psychoanalytic: II	in part by the player during play reversing his role as the passive recipient of strong unpleasant experience, and actively mastering another recipient in a similar way, thus purging the unpleasant effects	1. achieving mastery, even in a simulated experience, allows the elimination of the products of unpleasant experience by passing similar experiences on to other beings or objects	Both I and II ignore play that is not presumed to be motivated by the need to eliminate the products of strongly unpleasant experiences.
10. Developmental	by the way in which a child's mind develops. Thus play is caused by the growth of the child's intellect and is conditioned by it. Play occurs when the child can impose on reality his own conceptions and constraints	1. play involves the intellect 2. as a result of play, the intellect increases in complexity 3. this process in the human can be separated into stages 4. children pass through these stages in order	1. it doesn't account for play when and if the intellect ceases to develop
11. Learning	by the normal processes that produce learning	1. the child acts to increase the probability of pleasant events 2. the child acts to decrease the probability of unpleasant events 3. the environment is a complex of pleasant and unpleasant effects 4. the environment selects and energizes the play behaviors of its tenants	1. it doesn't account for behavior in situations where there are no apparent consequences (However this theory would maintain that there are no such settings.) 2. it doesn't account for the original contributions to behaviors made by an individual's genetic inheritance

Table 5.1

Modern Theories

NAME	PLAY IS CAUSED:	THIS EXPLANATION ASSUMES THAT:	IT CAN BE CRITICIZED BECAUSE:
12. Play as Arousal-Seeking	by the need to generate interactions with the environment or self that elevate arousal (level of interest or stimulation) towards the optimal for the individual	1. there is a need for optimal arousal 2. change in arousal towards optimal is pleasant 3. the organism learns the behaviors that result in that feeling and vice versa 4. stimuli vary in their capacity to arouse 5. stimuli that arouse are those involving novelty, complexity, and/or dissonance, i.e., information 6. the organism will be forced to emit changing behavior and maintain engagement with arousing stimuli	1. it is very general but it handles questions of work and play equally well. In fact it questions the validity of separating work from play
13. Competence/Effectance	by a need to produce effects in the environment. Such effects demonstrate competence and result in feelings of effectance	1. demonstration of competence leads to feelings of effectance 2. effectance is pleasant 3. effectance increases the probability of tests of competence	1. for the organism to constantly test whether it can still competently produce an effect seems to require uncertainty as to the outcome. Uncertainty or information seem to be the very attributes of stimuli that are arousing 2. it can be argued that competence/effectance behavior is a kind of arousal-seeking

APPENDIX B

STUDIES OF PLAY THERAPY OUTCOME WITH CHILDREN

STUDIES OF PLAY THERAPY OUTCOME WITH CHILDREN

Source	Area of Focus	Dependent Variables	Subjects	Treatment	Findings
Fleming & Synder, 1947	Social and personal adjustment	Roger's Personality Test, Sociometric Measures, Peer Rating Scale	7 children (3F, 4M) on basis of pre-test results	12 sessions	Greatest improvement in personal feelings of self; least improvement in social adjustment. Girls improved more than boys.
Cox, 1953	Interpersonal relations; personal adjustment	Thematic Apperception Test, Sociometric Measures, Adjustment Questionnaires.	18 children chosen from an orphanage population	10 sessions	Experimental group improved in peer rating scores, adjustment scores, and in projective measure
Dorfman,1958	Personal adjustment	Roger's Test of Personality Adjustment Machover Human Figure Drawing, Sentence Completion Form,Follow-up letters	12 boys,5 girls ages 9-12	19 sessions	Improvement on test scores
Seeman, Barry & Ellinwood,1964	Interpersonal relations	Tuddenham Reputation Test, Radke-Yarrow Teacher Rating Scale	16 children selected due to low adjustment scores on pre-test measures	37 sessions	Experimental group significantly less maladjusted
Schiffer,1966	Interpersonal relations; classroom begavior	Peer Nomination Inventory Classroom Behavior Observations	33 male clinic patients	Approximately 24 sessions	No improvement in therapy of placebo groups, but control group deterioration

Source	Area of Focus	Dependent Variables	Subjects	Treatment	Findings
Clement & Milne, 1967	Social and peral adjustment; anxiety, problem behaviors, academic achievement	Behavior Problem Checklist Playroom Observations Q-Sort Children's Manifest Anxiety Scale Grades in School	11 socially withdrawn boys	14 sessions	Treatment effect shown: increase in social approach behavior; decrease in discrete problem behavior. No improvement in anxiety or productivity
Elliot & Pumfrey, 1969	Social adjustment	Stott Bristol Adjustment Guides	8 and 9 year old boys of low average ability and low reading attainment	----	Treatment effect shown but may have been due to outside influences
Herd, 1969	Behavioral problems, interpersonal relationships	California Test of Personality, Vineland Social Maturity Model, Haggerty-Olson,Wickman Behavior Rating Scale, Sociometric Measure and School Grades	26 students referred due to behavior problems	10 sessions	No treatment effect produced, instruments may have been inadequate. Suggests longer treatment term, larger samples
West, 1969	Intellectual functioning,problem behaviors, emotional problems	Weschler Intelligence Scale for Children, Goodenough-Harris "Draw-A-Person", Self-Esteem Inventory School Apperception Method, Sociometric Measure	26 clinic patients (7F,19M) referred due to emotional, learning, or behavioral problems	10 sessions	No treatment produced effect. Recommendation of longer treatment term, larger sample, more stringent experimental assessment

Source	Area of Focus	Dependent Variables	Subjects	Treatment	Findings
Clement, Fazzone, & Goldstein, 1970	Social and personal adjustment problem behaviors emotional problems	Behavior Problem Checklist, Playroom Observations, Q-Sort, Grades in School	14 socially withdrawn 2nd & 3rd grade boys	20 sessions	Token reinforcement group improved more than verbal "free play" group. Verbal group improved more than control group
Quattlebaum, 1970	Self-concept	Rorschach, Draw-A-Person Test, Thematic Apperception Test	Maladjusted 5th grade students	16 sessions	No treatment produced effect
Drown,1971	Self-concept	———	Elementary Children	———	Group utilizing play media techniques showed most improvement
House, 1971	Self-concept, social adjustment	Scamin Self-Concept Scale, Sociometric Test	36 children (13 F, 13 M) identified as underchosen on a sociometric test	10 sessions	Improvement in self-concept but not sociometric status
Pelham, 1971	Social adjustment	Missouri Childrens' picture Series, Children's Self-Social Constructs Behavior Problem Checklist	35 kindergarten students identified as socially immature	6-8 sessions	Improvement in classroom behaviors; development of more complex self-concepts
Krivy, 1972	Adjustment, intellectual achievement	Sentence Completion, (Dorfman), Behavior Checklist (Erikson's Stages)	9 children identified as underachieving	7 sessions	Improvement in adjustment, but no significant differences on the Checklist. Suggestion that latter may not have been a valid instrument

Source	Area of Focus	Dependent Variables	Subjects	Treatment	Findings
McBrian & Nelson, 1972	Social status	Sociometric Test	Twelve elementary children with low sociometric scores	10 sessions	No treatment produced effect
Thombs & Muro, 1973	Interpersonal relations	Sociometric Scale	36 students identified as social isolates	15 sessions	Children in the play group improved over the control group but not over those in a verbal discussion group
Wall, 1973	Self-concept; motivation	Self-Concept Motivational Inventory Burk's Behavior Rating Scale	47 educationally handicapped children	24 sessions	Improvement in self-concept, motivation, and academics
Coltrane, 1974	Self-concept; peer status; "emotional expansiveness"; classroom behavior	Thomas Self-Concept Values Test Sociometric Test Behavior Rating Form	Thirty (13F, 17M), kindergarten children	10 sessions	Treatment effect shown
Barrett,1975	Social and personal adjustment; self-concept; academic self-concept; behavioral maturity	California Test of Personality Primary Self-Concept Inventory Behavioral Maturity Scale Coopersmith Self-Esteem Inventory	26 children identified as socially and psychologically maladjusted	15 sessions	Improvement in social adjustment only; suggested that a longer treatment term and more stringent instruments be used
Qualline,1975	Personal, social and behavioral adjustment	Vineland Social Maturity Scale, Child Behavior Rating Scale, Behavior Problem Checklist	24 preschool deaf children	10 sessions	Treatment effect produced;more mature behavioral patterns shown
Sabatini,1976	Interpersonal Relations	Social Choice Inventory, Video-tape Analysis	58 students	8 sessions	Treatment effect produced, but may have been influenced by outside factors

Source	Area of Focus	Dependent Variables	Subjects	Treatment	Findings
Stinton, 1977	Intellectual Achievement emotional and social adjustment	Weschler Intelligence Scale for Children-Revised, Children's Apperception Test, Coopersmith Self-Esteem Inventory and Behavior Rating Form, Wide Range Achievement Test, Beery Development Test of Visual-Motor Integration Bristol Social Adjustment Guide, Family Relations Test, Human Figure Drawing, Kinetic Family Drawing	Two (1F,1M) clinic patients	10-16 sessions	Treatment effect produced: quantitative gains on three tests having a perceptual element in common; qualitative gains in interpersonal relationships, school adjustment, self-concept, and family relations. Suggestion that more stringent assessment measures be used

APPENDIX C

TREATMENT GROUP DEFINITIONS

TREATMENT GROUP DEFINITIONS

Structured Group

G.M. Gazda's (1971, 1976) Developmental Approach to group counselling is the model employed in this treatment group. The focus of this model is on the developmental task behaviors (cf. Tryon,C. and Lilenthal, J.W., 1950) of the child. As defined by Havighurst,

> A developmental task is a task which arises at or about a certain period in the life of the individual, successful achievement of which leads to his happiness and to success with later tasks, while failure leads to unhappiness in the individual, disapproval by society, and difficulty with later tasks (Havighurst, 1952, p.2).

The value of this approach is that it allows the counsellor to accomodate children at various developmental stages and assist them in the learning of appropiate bahaviors necessary to successful task completion. The application of this approach, according to Gazda (1976), is as follows.

Modelling (vicarious and real-life) and other learning principles such as desensitization, shaping, operant conditioning, and assertive and discriminate training are used to selectively reinforce contextual and situationally appropriate behaviors. After three free-play sessions used to establish rapport the counsellor begins to structure the last half of the session using first story telling and puppetry as vicarious models for appropriate behaviors, then moving to dolls (to promote problem-solving in situations the counsellor creates), to sociodramas and psychodramas revolving around school and family situations and interactions occurring in the group to foster appropriate behaviors. Throughout this process operant learning principles are used to shape and reinforce appropriate behavior. The media selected for their play and action qualities are used to promote relationship development and

problem resoultion and are not therefore the primary focus of treatment (Reynolds, 1978).

Unstructured Group

The emphasis in Clark Moustakas' relationship therapy (1953, 1959, 1966, 1975) is on the dynamics of the relationship which develops between the therapist and the child: "the focus is always on the present living experience" (Moustakas, 1959, p.2). Moustakas' views on the nature of the child are essentially the same as the client-centered orientation (cf. Axline, 1947). A critical difference between the two is that in relationship therapy the therapist plays a much more active role in the process, i.e., he will play with the child. This type of play therapy is more like a partnership with the two people working together.

Within relationship play therapy, seven basic principles are followed in order to facilitate the positive growth of the child:

1. There should be some provision for a selected quantity and variety of play materials, both structured and unstructured, so that the child is free to select the type or quality of materials he needs.
2. The child should be given ample opportunity to verbalize his emotions.
3. The adult should listen to the child's verbalizations, particualry to the feelings, and in some way indicate acceptance and understanding of them.
4. The child should decide whether or not he wishes to use the materials and whether or not he wishes to verbalize his feelings.
5. By his manner, reflection, expressions, and tone the adult should show the child that he accepts his feelings as they are, neither criticizing nor approving but remaining totally acceptive.
6. Children should be permitted to express what they wish and not be obliged to follow a model or a product that meets a social or art standard.
7. No attempt should be made to interpret to the child the symbolism involved in his play. Unless the adult makes the correct interpretation (an interpretation which coincides with the child's interpretations at that moment), the adult may generate

> disturbed feelings rather than aid the child in expressing them and working them through in his own way. The child's own judgement and expressed feelings provide the best clues to the meaning of the child's play and these should be accepted exactly as they are (Moustakas, 1953, p.226).

APPENDIX D

COOPERSMITH SELF-ESTEEM INVENTORY

SELF-ESTEEM INVENTORY (SEI)

Please mark each statement in the following way:
the statement describes how you usually feel, put a check in the column "LIKE ME"
the statement does not describe how you usually feel, put heck ( ) in the column "UNLIKE ME."
There are no right or wrong answers.

	LIKE ME	UNLIKE ME
I spend a lot of time daydreaming.		
I'm pretty sure of myself.		
I often wish I were someone else.		
I'm easy to like.		
My parent and I have a lot of fun together.		
I never worry about anything.		
I find it very hard to talk in front of the class.		
I wish I were younger.		
There are lots of things about myself I'd change if I could.		
I can make up my mind without too much trouble.		
I'm a lot of fun to be with.		
I get upset easily at home.		

	LIKE ME	UNLIKE ME
I always do the right thing.		
I'm proud of my school work.		
Someone always has to tell me what to do.		
It takes me a long time to get used to anything new.		
I'm often sorry for the things I do.		
I'm popular with kids my own age.		
My parents usually consider my feelings.		
I'm never unhappy.		
I'm doing the best work that I can.		
I give in very easily.		
I can usually take care of myself.		
I'm pretty happy.		
I would rather play with children younger than me.		
My parents expect too much of me.		
I like everyone I know.		
I like to be called on in class.		
I understand myself.		
It's pretty tough to be me.		

	LIKE ME	UNLIKE ME
. Things are all mixed up in my life.		
. Kids usually follow my ideas.		
. No one pays much attention to me at home.		
. I never get scolded.		
. I'm not doing as well in school as I'd like to.		
. I can make up my mind and stick to it.		
. I really don't like being a boy - girl.		
. I have a low opinion of myself.		
. I don't like to be with other people.		
. There are many times when I'd like to leave home.		
. I'm never shy.		
. I often feel upset in school.		
. I often feel ashamed of myself.		
. I'm not as nice looking as most people.		
. If I have something to say, I usually say it.		
. Kids pick on me very often.		
. My parents understand me .		
. I always tell the truth.		
. My teacher makes me feel I'm not good enough.		
. I don't care what happens to me.		

	LIKE ME	UNLIKE ME
1. I'm a failure.		
2. I get upset easily when I'm scolded.		
3. Most people are better liked than I am.		
4. I usually feel as if my parents are pushing me.		
5. I always know what to say to people.		
6. I often get discouraged in school.		
7. Things usually don't bother me.		
8. I can't be depended on.		

APPENDIX E

COOPERSMITH BEHAVIOR RATING FORM

Behavior Rating Form (BRF)

1. Does this child adopt easily to new situations, feel comfortable in new settings, enter easily into new activities?

   ..... always .....usually .....sometimes

   .....seldom .....never.

2. Does this child hesitate to express his opinions, as evidenced by extreme caution, failure to contribute, or a subdued manner in speaking situations?

   .....always .....usually .....sometimes .....

   seldom .....never

3. Does this child become upset by failures or other strong stresses as evidenced by such behaviors as pouting, whining, or withdrawing?

   .....always .....usually .....sometimes ...seldom

   .....never

4. How often is this child chosen for activities by his classmates? Is his companionship sought for and valued?

.....always .....usually .....sometimes ....seldom

.....never

5. Does this child become alarmed or frightened easily? Does he become very restless or jittery when procedures are changed, exams are scheduled or strange individuals are in the room?

.....always ....usually ....sometimes ....seldom

.....never

6. Does this child seek much support and reassurance from his peers or the teacher, as evidenced by seeking their nearness or frequent inquiries as to whether he is doing well?

.....always .....usually ....sometimes ....seldom

.....never

7. When this child is scolded or criticized, does he become either very aggressive or very sullen and submissive?

.....always ....usually .....sometimes ....seldom

.....never

8. Does this child deprecate his school work, grades, activities, and work products? Does he indicate he is not doing well as expected?

.....always .....usually ....sometimes ...seldom

.....never

9. Does this child show confidence and assurance in his actions toward his teachers and classmates?

.....always .....usually ....sometimes ...seldom

.....never

10. To what extent does this child show a sense of sel-esteem, self-respect, and appreciation of his own worthiness?

.....very strong .....strong .....medium ...mild

.....weak

11. Does this child publicly brag or boast about his exploits?

.....always ....usually ....sometimes ...seldom

.....never

12. Does this child attempt to dominate or bully other children?

.....always ....usually ....sometimes ....seldom

.....never

13. Does this child continually seek attention, as evidenced by such behaviors as speaking out of turn and making unnecessary noises?

.....always .....usually ....sometimes ...seldom

.....never

APPENDIX F

THE GENERAL ANXIETY SCALE FOR CHILDREN

SARASON

GENERAL ANXIETY SCALE FOR CHILDREN

1. When you are away from home, do you worry about what might be happening at home?

2. Do you sometimes worry about whether
   (other children are better looking than you are?)
   (your body is growing the way it should?)

3. Are you afraid of mice or rats?

4. Do you ever worry about knowing your lessons?

5. If you were to climb a ladder, would you worry about falling off it?

6. Do you worry about whether your mother is going to get sick?

7. Do you get scared when you have to walk home alone at night?

8. Do you ever worry about what other people think of you?

9. Do you get a funny feeling when you see blood?

10. When your father is away from home, do you worry about whether he is going to come back?

11. Are you frightened by lightening and thunderstorms/

12. Do you ever worry that you won't be able to do something you want to do?

13. When you go to the dentist, do you worry that he might hurt you?

14. Are you afraid of things like snakes?

15. When you are in bed at night trying to go to sleep, do you often find that you are worrying about something?

16. When you were younger, were you ever scared of anything?

17. Are you sometimes frightened when looking down from a high place?

18. Do you get worried when you have to go to the doctor's office?

19. Do some of the stories on radio or television scare you?

20. Have you ever been afraid of getting hurt?

21. When you are alone at home and someone knocks at the door, do you get a worried feeling?

22. Do you get a scary feeling when you see a dead animal?

23. Do you think you worry more than other boys and girls?

24. Do you worry that you might get hurt in some accident?

25. Has anyone ever been able to scare you?

26. Are you afraid of things like guns?

27. Without knowing why, do you sometimes get a funny feeling in your stomach?

28. Are you afraid of being bitten or hurt by a dog?

29. Do you ever worry about something bad happening to someone you know?

30. Do you worry when you are home alone at night?

31. Are you afraid of being too near fireworks because of their exploding?

32. Do you worry that you are going to get sick?

33. Are you ever unhappy?

34. When your mother is away from home, do you worry about whether she is going to come back?

35. Are you afraid to dive into the water because you might get hurt?

36. Do you get a funny feeling when you touch something that has a real sharp edge?

37. Do you ever worry about what is going to happen?

38. Do you get scared when you have to go into a dark room?

39. Do you dislike getting in fights because you worry about getting hurt in them?

40. Do you worry about whether your father is going to get sick?

41. Have you ever had a scary dream?

42. Are you afraid of spiders?

43. Do you sometimes get the feeling that something bad is going to happen to you?

44. When you are alone in a room and you hear a strange noise, so you get a frightened feeling?

45. Do you ever worry?

APPENDIX G

LOCUS OF CONTROL SCALE FOR CHILDREN

THE NOWICKI-STRICKLAND PERSONAL REACTION SURVEY

+1. Do you believe that most problems will solve themselves if you just don't fool with them?

(Yes) No

2. Do you believe that you can stop yourself from catching a cold? (N)

*3. Are some kids just born lucky? (Y)

4. Most of the time do you feel that getting food grades means a great deal to you? (N)

+5. Are you often blamed for things that just aren't your fault? (Y)

6. Do you believe that if somebody studies hard enough he or she can pass any subject? (N)

*+7. Do you feel that most of the time it doesn't pay to try hard because things never turn out right anyway? (Y)

8. Do you feel that if things start out well in the morning that it's going to be a good day no matter what you do? (Y)

*+9. Do you feel that most of the time parents listen to what their children have to say? (N)

*10. Do you believe that wishing can make good things happen? (Y)

+11. When you get punished does it usually seem it's for no good reason at all? (Y)

+12. Most of the time do you find it hard to change a friend's (mind) opinion? (Y)

13. Do you think that cheering more than luck helps a team to win? (N)

*+14. Do you feel that it's nearly impossible to change your parent's mind about anything? (Y)

15. Do you believe that your parents should allow you to make most of your own decisions? (N)

*+16. Do you feel that when you do something wrong there's very little you can do to make it right? (Y)

*+17. Do you believe that most kids are just born good at sports?(Y)

*18. Are most of the other kids your age stronger than your are?(Y)

*+19. Do you feel that one of the best ways to handle most problems is just not to think about them? (Y)

20. Do you feel that you have a lot of choice in deciding who your friends are? (N)

21. If you find a four leaf clover do you believe that it might bring you good luck? (Y)

22. Do you often feel that whether you do your homework has much to do with what kind of grades you get? (N)

*+23. Do you feel that when a kid your age decides to hit you, there's little you can do to stop him or her? (Y)

24. Have you ever had a good luck charm? (Y)

25. Do you believe that whether or not people like you depends on how you act? (N)

26. Will your parents usually help you if you ask them to? (N)

*+27. Have you felt that when people were mean to you it was usually for no reason at all. (Y)

+28. Most of the time, do you feel that you can change what might happen tomorrow by what you do today? (N)

*+29. Do you believe that when bad things are going to happen they just are going to happen no matter what your try to do to stop them? (N)

30. Do you think that kids can get their own way if they just keep trying? (N)

*+31. Most of the time do you find it useless to try to get your own way at home? (Y)

32. Do you feel that when good tings happen they happen because of hard work? (N)

*+33. Do you feel that when somebody your age wants to be your

enemy there's little you can do to change matters? (Y)

34. Do you feel that it's easy to get friends to do what you want them to? (N)

*+35. Do you usually feel that you have little to say about what you get to eat at home? (Y)

*+36. Do you feel that when someone doesn't like you there's little you can do about it? (Y)

*+37. Do you usually feel that it's almost useless to try in school because most other children are just plain smarter than you are? (Y)

*+38. Are you the kind of person who believes that planning ahead makes things turn out better? (N)

*+39. Most of the time, do you feel that you have little to say about what your family decides to do? (Y)

40. Do you think it's better to be smart than to be lucky?(N)

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* Items selected for abbreviated scale for grades 3-6.
+ Items selected for abbreviated scale for grades 7-12.

APPENDIX H

SUPPLEMENTARY DATA

SUPPLEMENTARY DATA

Table 11

Test for Equality of Pre-test Means Across Groups

Measure	Source	df	M.S.	F	Probability Level
Self-Esteem Inventory	Cov 1	1	587.97	4.47	0.06
Behavior Rating Form	Cov 1	1	152.75	4.62	0.06
General Anxiety Scale	Cov 1	1	736.73	25.12	0.0005
Locus of Control Scale	Cov 1	1	8.82	2.96	0.11

Table 12

Means and Adjusted Means of Self-Esteem Scores for the Three Groups Employed in the Study

Groups	Pre-test Means	Post-test Means	Adjusted Means
Treatment 1	80.80	82.40	13.86
Treatment 2	70.50	72.50	11.60
Control	66.40	70.80	8.83

Table 13

Means and Adjusted Means of Behavior Scores
for the Three Groups Employed in the Study

Groups	Pre-test Means	Post-test Means	Adjusted Means
Treatment 1	46.40	43.60	13.83
Treatment 2	47.25	47.25	11.96
Control	47.20	46.00	12.84

Table 14

Means and Adjusted Means of Anxiety Scores
for the Three Groups employed in the Study

Groups	Pre-test Means	Post-test Means	Adjusted Means
Treatment 1	27.40	31.80	1.41
Treatment 2	21.75	26.50	0.15
Control	20.00	19.40	4.18

Table 15

Means and Adjusted Means of Locus of Control Scores for the Three Groups Employed in the Study

Groups	Pre-test Means	Post-test Means	Adjusted Means
Treatment 1	7.20	10.40	3.48
Treatment 2	10.50	10.25	6.83
Control	10.80	11.60	6.65

Table 16

Multiple Comparison of Group Mean Differences on the Dimension of Internality

Source	Lower	Upper	F
$G_2 - G_1$	0.04	6.67	4.19*
$G_3 - G_1$	-0.03	6.38	4.01*
$G_3 - G_2$	-3.59	3.23	0.01

* $p < .05$